THE NATURE OF CLIENT SATISFACTION WITH COMMUNITY AND CLINIC BASED OPIOID REPLACEMENT TREATMENT: A RESOURCE EXCHANGE PERSPECTIVE

Myra Whitney

A thesis submitted in partial accordance with the requirements for admission to the degree of Doctor of Philosophy (Clinical Psychology) of the Australian National University

December 2005
This thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university. To the best of my knowledge and apart from due reference, it does not contain any material previously published or written by another person. Aside from the acknowledged assistance of others, the work herein is my own.

Myra Whitney
Canberra, 2005
Acknowledgments

This project would not have been completed without the support and guidance of my principal supervisor, Dr Jeff Ward, who responded to my lapses in faith, purpose and statistical understanding all with tireless equanimity. Perhaps more importantly, without his openness to ideas, appreciation of intellectual freedom and capacity to communicate these values, the work would never have begun. I am grateful for the experience and encouragement of panel members Dr Mike Smithson and Dr Mark Doverty as well as the advice proffered by Dr Gabriele Bammer in the early stages of my candidature.

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Finally, I wish to acknowledge the unwavering support of my partner Roland Trebesius, who has taught me much about the nature of satisfaction.

This work is dedicated to Max.
Abstract

One of the defining features of contemporary opioid replacement treatment in Australia is its diversity of format and operation. The impact on treatment effectiveness of this diversity, reflected in public and private sector modes of treatment and clinic and community forms of delivery, is only starting to be understood. This thesis reports a single cross-sectional case study of a public sector program containing both clinic and private community formats aimed at identifying the level of client satisfaction with a program structured in this way. In the absence of an adequate theory suitable for use in a health care context, a model was developed to assess the issue. A modified version of Thompson and Sunol's (1995) assimilation-contrast theory was used to assess client satisfaction and resource exchange theory (Foa & Foa, 1974) was used to classify the domains of treatment nominated by clients as significant in their care. An analysis of the program's structure revealed that the expectations clients develop about their treatment are influenced by whether they receive care in either the clinic or community sector of the program, where noticeable differences in the degree of supervision clients receive can be observed. A comparison of the profiles of clients in the two areas of the program indicated that clinic clients have greater psychological and social needs, are more likely to continue to use illicit drugs and to have had more attempts at treatment than their community counterparts. The assessment of client satisfaction revealed that, on the basis of the model used in this thesis, clients are largely satisfied with treatment. This occurs because clinic clients adjust their expectations to accommodate their more regular experiences of disappointment and community clients tend to experience many pleasant surprises in treatment. Where dissatisfaction arises, it has more negative personal consequences for clinic clients than for community clients, particularly regarding the processes of treatment delivery as distinct from the content of the treatment itself. Overall, these results, while representing the views of approximately one-third of the clients in the program, suggest that the current policy of matching clients with particular needs to special types of treatment appears to be successful. Further research is required to confirm the utility of the proposed model of client satisfaction in health care research more generally.
## Contents

Acknowledgments ........................................................................................................ iii
Abstract ........................................................................................................................ iv
Contents ........................................................................................................................ v
Tables and Figures ....................................................................................................... ix
Abbreviations .............................................................................................................. xi

**Chapter 1 – Introduction and Overview ................................................................. 1**

**Chapter 2 – Core Concepts in the Evaluation of Contemporary Opioid Replacement Therapy ................................................................. 5**
- Introduction .............................................................................................................. 5
- Opioid Replacement Therapy: Adoption and Current Format ................................ 5
  - Establishment in Australia .................................................................................... 6
  - Current Australian Delivery Format ..................................................................... 8
- Future Directions for Research in Contemporary Opioid Replacement Therapy ................................................................. 10
- Assessing Treatment Effectiveness in Opioid Replacement Therapy: An Overview ................................................................. 14
  - Outcome Effectiveness ........................................................................................ 14
  - The Influence of Client Characteristics .............................................................. 15
  - Process Effectiveness .......................................................................................... 16
- Indicators of Treatment Process Effectiveness ......................................................... 17
  - Program Policy: Treatment Orientation .............................................................. 18
  - Nature of Client-Staff Relationships ................................................................... 20
  - Administrative and Organisational Arrangements: Treatment Fees .................... 23
  - Dosing Arrangements ......................................................................................... 24
  - Ancillary Services ............................................................................................... 26
- Assessing Treatment Process Effectiveness: Obtaining the Client’s Perspective ...... 26
- Conclusion .............................................................................................................. 29

**Chapter 3 – Assessing Client Satisfaction with Opioid Replacement Treatment: A Resource Exchange Perspective ................................................................. 31**
- Introduction .............................................................................................................. 31
- The Status of Research into Client Satisfaction with Opioid Replacement Therapy 32
  - Purpose, Scope and Approach .......................................................................... 32
  - Areas for Development ....................................................................................... 34
- Theoretical Issues in the Assessment of Client Satisfaction ...................................... 37
  - Current Conceptualisations of Satisfaction ....................................................... 37
  - The Application of Assimilation-Contrast Models of Satisfaction ....................... 42
  - Areas for Development ....................................................................................... 43
  - A Reformulation of the Satisfaction Construct ................................................... 45
- Classifying the Domains of Assessment: Client Satisfaction as a Function of Interpersonal Exchange ................................................................. 49
  - Satisfaction From a Social Exchange Perspective .............................................. 50
  - The Utility of Resource Theory in Assessing Social Exchanges ......................... 51
  - Applying Resource Theory in Classifying the Domains of Assessment ............... 52
Chapter 7 – Client Satisfaction with Opioid Replacement Treatment in the Southern Area Health Service: Profile of Respondents

Chapter 8 – Client Satisfaction with Opioid Replacement Treatment in the Southern Area Health Service: Respondent Evaluations

Chapter 9 - Conclusion: The Value of Assessing Client Satisfaction with Opioid Replacement Treatment
Client Satisfaction as an Indicator of Treatment Effectiveness ........................................... 218
The Pharmacotherapy ........................................................................................................ 218
Dosing Arrangements ........................................................................................................ 219
Ancillary Services ............................................................................................................ 222
The Cost of Treatment ...................................................................................................... 222
The Quality of Staff-Client Relationships ...................................................................... 223
The Influence of Client Characteristics .......................................................................... 225
The Influence of Program Structure and Provider Philosophy ....................................... 227
The Effectiveness of the Model of Client Satisfaction ...................................................... 229
The Importance of Expectations in Client Evaluations ..................................................... 229
The Utility of Resource Exchange Theory in Assessing the Domains of Treatment .... 232
Conclusions and Recommendations .................................................................................. 233

References .......................................................................................................................... 236
Software .............................................................................................................................. 251
Appendices ........................................................................................................................ 252
  Appendix A – List of Inductive Coding Themes and Descriptors for Service Provider Interviews ............................................................. 252
  Appendix B – Conceptually Ordered Matrix of Service Provider Approaches to Relationships with Clients ...................................................... 256
  Appendix C – List of Inductive Coding Themes and Descriptors for Client Focus Groups ........................................................................ 257
  Appendix D – Conceptually Ordered Matrix of Client Resource Exchanges ........ 261
  Appendix E – Client Questionnaire .............................................................................. 262
  Appendix F – Coding System for Transcripts of Client Interviews ............................. 276
  Appendix G – Coding Summary Sheet ......................................................................... 287
  Appendix H – Subset Codes for the Resource Categories ............................................ 290
Tables and Figures

Table 2.1 Number of Methadone Clients in Australia by State and Territory, 2001.

Figure 3.1 Anderson's Assimilation-Contrast Model of Satisfaction.

Figure 3.2 Thompson and Sunol's Assimilation-Contrast Model of Satisfaction.

Figure 3.3 Proposed Assimilation-Contrast Model of Satisfaction.

Figure 3.4 Circumplex of the Six Resource Classes.

Figure 4.1 Conceptual Framework for an Investigation of the Operation of Client Satisfaction Judgments in Opioid Replacement Therapy.

Table 5.1 Clinical Caseload and Frequency of Peer Contact of Service Providers.

Table 5.2 Interview Schedule for Service Providers.

Table 5.3 Number of Clinic and Community Based Clients in the Opioid Agonist Treatment Service by Treatment District as at June 2002.

Table 5.4 Number of Methadone and Buprenorphine Clients in New South Wales by Region of Treatment and Gender, 2003.

Table 6.1 Clinical Profile of Focus Group Participants.

Table 6.2 Questioning Route for Focus Groups.

Table 6.3 Definitions of the Resource Categories Used to Assign Descriptive Codes.

Table 7.1 Age, Gender and Education of Client Sample.

Table 7.2 Relationship Status of Client Sample.

Table 7.3 Employment Status of Client Sample.

Table 7.4 Current Treatment Type of Client Sample.

Table 7.5 Duration of Opioid Replacement Treatment, Including in the Southern Area Health Service, and Number of Treatment Registrations of Client Sample.

Table 7.6 Number of Clients with Experience of Treatments Other Than Maintenance Opioid Replacement Therapy.

Table 7.7 Level, Stability and Perceived Appropriateness of Current Dose of Client Sample.
Table 7.8  Expected Duration of Opioid Replacement Treatment of Client Sample

Table 7.9  Client Age of First Drug Use and Drug Type at First Use

Table 7.10  Drug Type Identified as Current Problem and Perceived seriousness of Problem

Table 7.11  Client Heroin Use in the Preceding Month

Table 7.12  Amount of Heroin Used on the Last Day of Use

Table 7.13  Number of Client Physical Health Symptoms, Including Symptoms Related to Opioid Dependence, in the Preceding Month

Table 7.14  Highest MCMI Clinical Syndrome Score Indicating a Diagnosable Clinical Disorder (BR85+)

Table 7.15  Highest MCMI Personality Pattern Score Indicating a Diagnosable Personality Disorder (BR85+)

Table 7.16  MCMI Modifying Index Scores

Table 8.1  Interview Schedule for Clients

Table 8.2  Number of Important Issues or Events by Client Type, Resource Category and Outcome

Table 8.3  Number of Important Issues or Events by Client Type, Resource Category Subset and Outcome

Table 8.4  Number of Important Issues and Events by Source, Resource Type and Valence

Figure 8.1  The Effects of Client Dissatisfaction with the Process of Treatment Delivery

Figure 8.2  The Effects of Client Dissatisfaction with Specific Treatment Components

Figure 8.3  The Effects of Client Satisfaction with the Process of Treatment Delivery

Figure 8.4  The Effects of Client Satisfaction with Specific Treatment Components

Figure 9.1  The Model of Client Satisfaction Tested in this Research
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CSQ</td>
<td>Client Satisfaction Questionnaire</td>
</tr>
<tr>
<td>MCMI</td>
<td>Millon Clinical Multiaxial Inventory</td>
</tr>
<tr>
<td>MMT</td>
<td>Methadone Maintenance Therapy</td>
</tr>
<tr>
<td>ORT</td>
<td>Opioid Replacement Therapy</td>
</tr>
<tr>
<td>SAHS</td>
<td>Southern Area Health Service</td>
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</table>
Chapter 1 – Introduction and Overview

Opioid replacement therapies offered in a maintenance rather than a detoxification format, such as methadone treatment, have a clearly established record in reducing the social and individual harm associated with illicit opioid use. In the last 15 years, there has been an increasing diversification in the forms of these treatments in Australia and the means by which they are delivered. This has been partly a product of demands for greater economic efficiencies in the health care sector generally and partly a response to calls to increase the attractiveness of these treatments to prospective users of them. As such, opioid dependent individuals who seek treatment at the present time now have a choice of pharmacotherapies as well as a variety of formats in which to receive them. For example, they may obtain free daily treatment through a public clinic providing specialist drug treatment services or pay dispensing fees to either a specialist private clinic or a local community provider, such as a pharmacy. These choices are further complicated given that the guidelines which stipulate how treatment should be delivered in each of these modalities differ across state jurisdictions and individual providers retain the power to arrange services as they wish.

The impact of the variation in this complex service environment on the effectiveness of treatment has received little attention. The bulk of research into the efficacy of opioid replacement treatment has focused on methadone and on its administration in specialist clinic environments. Of the few evaluations that have examined the effect of the treatment milieu on client outcomes, aspects of the treatment’s structure and operation, particularly staff and client interactions, have been found to make an important contribution to treatment effectiveness (Ball & Ross, 1991). Moreover, issues specific to the newer treatment modalities such as community dispensing that had not previously been examined, such as dispensing fees and client confidentiality, have been found to have a role to play in client engagement in treatment (Lintzeris, Koutroulis, Odgers, Ezard, Lanagan, Muheisen et al., 1996). In short, determining how clients can be best matched to a treatment suited to their needs and determining the extent to which treatment programs can qualitatively vary before
treatment effectiveness is impeded makes evaluations of treatment process an important focus of current research into opioid replacement therapy.

Treatment effectiveness in opioid replacement therapy has been traditionally measured by examining the influence of both client characteristics, such as age, gender and drug use history, and treatment processes, such as maintenance or abstinence oriented treatment, on changes in client health and social adaptation. While these are important indices of a treatment’s effectiveness, they are often incomplete because they conceptualise clients as passive recipients of the treatment process. In order to address this problem and in recognition of the contribution that client feedback makes to improvements in clinical practice, the last 15 years has seen a greater emphasis placed on assessing client satisfaction with services.

At present, the research literature on client satisfaction with opioid replacement therapy is sparse. Most of it has examined client and program variables either associated with or predictive of client satisfaction. Like research on client satisfaction in other health care areas, regardless of the type of client or program, almost universal levels of high or very high satisfaction have been reported in these studies even when the results of interviews with clients would suggest otherwise. Further, no clear associations have been obtained regarding the influence of client and program factors on rated satisfaction.

A review of the broader literature on client satisfaction reveals that the methodological difficulties underscoring research on this topic in opioid replacement treatment are the result of deeper conceptual problems. In sum, these are the lack of a uniformly accepted definition of the concept and a theory specifying the operation of its core features and the domains of treatment in which it applies. The most recent coherent theoretical development on client satisfaction has occurred in the field of consumer marketing research (Thompson & Sunol, 1995). Based on the popular assumption that satisfaction judgments are evaluations of the worth of an experience according to some standard, such as an expectation, this theory accounts for the relativity or contextual nature of client assessments. Further, through assumptions about the way clients adjust
their expectations in relation to their experiences, the theory can account for why current instruments used to measure satisfaction consistently register it at high levels.

Differences in assumptions about the way consumers evaluate ad hoc customer service encounters and long-term clients evaluate their health care necessitated a revision of this model for use in assessing client satisfaction in opioid replacement therapy. The essence of this revision was the assumption that a satisfactory treatment experience for someone receiving chronic care is the product of the accuracy or appropriateness of the treatment to the client’s expectations, not an experience that exceeds his or her sense of what it is ‘normal’ to expect in that environment. As such, health care clients are most satisfied when their treatment is stable and reliable, not wildly unanticipated.

A second component of the theoretical work was finding a coherent system for classifying the domains of treatment affected by client satisfaction judgments without pre-empting which aspects of treatment clients would nominate as important. Resource exchange theory was adopted for this purpose (Foa & Foa, 1974). Essentially a descriptive theory identifying the fundamental categories of literal and symbolic resources transacted universally in social exchanges, resource exchange theory was considered capable of accounting for the interpersonal manner in which treatment is delivered as well as the effectiveness of the various components that define the treatment in and of itself, such as particular goods and services.

Given the state of research on client satisfaction with opioid replacement therapy, the project reported in this thesis was defined by two general aims. The principal aim was to evaluate client satisfaction with opioid replacement therapy in the current Australian treatment environment. A secondary aim was to explore the operation of the theoretical model of client satisfaction developed for this purpose to assess its suitability for application in other health care domains. A case study of a public sector program in New South Wales, Australia, using both clinic and community based providers was considered the most effective means of meeting these aims. It spans three empirical studies. The first describes the structure and operation of the clinic
and community sectors of the program and the treatment approach of its main providers in coordinating clinical responsibilities across both these sectors. This provides the context within which client evaluations of treatment are formed. The second study seeks to assess the utility of using resource exchange theory to classify issues considered important by clients of the program. As such, it is a pilot study of client evaluations of treatment. The third study is the main assessment of client satisfaction in the program. It comprises two parts. One is a description of the profile of clients in the program which attempts to identify whether there are any personal differences in the types of clients who attend the clinic and community sectors of the program. The other is the main assessment of client satisfaction with the various domains of treatment in the program using the proposed theoretical model.

The plan of the thesis is divided in four sections and presented in the form of a literature review, a methodological overview, the empirical studies and a conclusion. Chapter 2 reviews the development of opioid replacement treatment in Australia and highlights the concepts and issues that need to be addressed in any evaluation of current treatment conditions. Chapter 3 reviews the literature on client satisfaction in opioid replacement therapy and the broader health care environment and describes the theoretical model used in this evaluation. Chapter 4 outlines the methods used to acquire the necessary data for the project and provides a detailed plan of the empirical research. Chapters 5 to 8 report the results of the three studies used to assess client satisfaction in the program. Chapter 9 provides a summary of the research and evaluates the usefulness of assessing client satisfaction with the model developed in this project.
Chapter 2 – Core Concepts in the Evaluation of Contemporary Opioid Replacement Therapy

Introduction

This chapter describes the adoption and expansion of current maintenance treatment methods and modalities for opioid dependence in Australia and delineates the most appropriate means used to evaluate their effectiveness. To this end, it aims to highlight the diversity in service delivery that exists across both public and private sector modes of treatment and across Australian jurisdictions, particularly as it manifests in clinic and community based treatment formats. It also aims to show that a consequence of this complex treatment system has been a necessary expansion in scope of evaluative research to incorporate not only client outcomes from treatment but also process indicators of treatment program efficacy. The final section of the chapter outlines the concepts of greatest relevance to evaluations of contemporary opioid replacement therapy based on these considerations. The usefulness of assessing client satisfaction to investigate their impact is considered in this context.

Opioid Replacement Therapy: Adoption and Current Format

Opioid replacement therapy involves the provision of a long-lasting substitute opioid analgesic to individuals dependent on any one of a range of opioids, most predominantly heroin but also potentially morphine, pethidine, codeine and illicit methadone. Administered orally, it aims to improve the health and wellbeing of opioid-dependent individuals by largely reducing, if not eliminating, their injection of illicit opioids. Of all opioid substitution treatments, methadone, provided in a long-term stabilising maintenance dose rather than a short-term reduction dose, has the longest history of use in Western countries. At present, it continues to be the most widely used and the most effective synthetic drug for eliminating heroin withdrawal symptoms, including in Australia (Bell, Dru, Fischer, Levit & Sarfraz, 2002; Mattick, Digiusto, Doran, O’Brien, Shanahan, Kimber et al., 2004). Over the last 15 years or so, however, treatments such as buprenorphine, naloxone, naltrexone and levo-acetylmethadol (LAAM) have been clinically demonstrated to be promising alternative
pharmacotherapies to methadone treatment. Of these, buprenorphine has had the widest uptake as an alternative opioid maintenance therapy in Australia to date. As such, this thesis deals with the issues involved in the administration of methadone and buprenorphine treatment only.

Establishment in Australia

Maintenance doses of methadone were introduced as a drug substitution treatment for opioid dependence in the USA in the early 1960s (Dole & Nyswander, 1965). Used to remove cravings for heroin and block its euphoric effects, methadone syrup needed to be taken only once a day because its long-acting nature removed opiate withdrawal symptoms for 24 to 36 hours. This enabled affected individuals to take advantage of the ancillary aspects of the treatment, such as psychotherapy and other rehabilitative programs, to improve their emotional and social wellbeing.

Methadone maintenance therapy was introduced into Australia in 1968 and first administered in a public treatment program by British psychiatrist Dr Stella Dalton in New South Wales in 1970 (Caplehorn & Batey, 1992). The growth of the treatment reflected the North American and British experience where, following an initial period of rapid expansion until the mid-1970s, the attractiveness of methadone treatment waned following a lack of agreement about its objectives. Since 1985, following a rise in public and political concern about crime, the increasing incidence of illicit drug use and the spread of the human immunodeficiency virus (HIV) among illicit drug users, the federal government established a set of national guidelines endorsing methadone maintenance therapy as the treatment of choice for heroin dependence, resulting in a second period of rapid growth of the therapy. This resulted in methadone maintenance programs being established in every state and territory in Australia, with the exception of the Northern Territory, and a large rise in the number of registered methadone clients. Government agency reports since that time reveal a 470 per cent increase in the total number of clients enrolled in methadone treatment services Australia-wide between 1986 and 1998, where the number of enrolments reached 24,657 as at June 1998 (Higgins, Cooper-Stanbury & Williams, 2000). By 2001, this figure was estimated
to be 31,995 (Australian Institute of Health and Welfare, 2003). Table 3.1 shows the break-up by state and territory of the number of clients in treatment in 2001 in both public and private sector programs, the latter of which developed in response to lags in the expansion of services in the public sector in the mid-1980s (Caplehorn & Batey, 1992). As can be seen, the New South Wales programs contain just under half of the total number of methadone clients in Australia.

Table 2.1 Number of Methadone Clients in Australia by State and Territory, 2001

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Public Sector</th>
<th>Private Sector</th>
<th>Prison Program</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>2,978</td>
<td>10,473</td>
<td>1,514</td>
<td>14,965</td>
</tr>
<tr>
<td>Victoria</td>
<td>117</td>
<td>7,694</td>
<td>215</td>
<td>8,026</td>
</tr>
<tr>
<td>Queensland</td>
<td>3,302</td>
<td>564</td>
<td>-</td>
<td>3,866</td>
</tr>
<tr>
<td>Western Australia</td>
<td>683</td>
<td>1,512</td>
<td>-</td>
<td>2,195</td>
</tr>
<tr>
<td>South Australia</td>
<td>838</td>
<td>1,418</td>
<td>178</td>
<td>2,434</td>
</tr>
<tr>
<td>Tasmania</td>
<td>66</td>
<td>375</td>
<td>4</td>
<td>445</td>
</tr>
<tr>
<td>ACT</td>
<td>265</td>
<td>383</td>
<td>-</td>
<td>648</td>
</tr>
<tr>
<td>Australia</td>
<td>8,249</td>
<td>22,419</td>
<td>1,911</td>
<td>31,995</td>
</tr>
</tbody>
</table>


Table 3.1 also shows that private sector methadone provision currently accounts for the largest number of clients in each state. Under this model, general practitioners (GPs) and psychiatrists are licensed by the state governments to prescribe methadone to opioid dependent people. Their medical services are bulk-billed under the national health insurance system of Medicare but, unlike government programs, which are free, clients pay a dispensing fee that averages around $40 to $50 per week (Hall, Ward & Mattick, 1998). Private sector services may be provided in a specialised clinic format, where prescribing and dispensing are conducted at the one site to usually a large number of clients. They may also be offered through a combination of individual community based medical practitioners and allied local retail pharmacies, who deal with comparatively small numbers of clients (often less than 25) (Bell, Ward, Mattick, Hay, Chan & Hall, 1995).
Current Australian Delivery Format

In the 20 years since the development of national guidelines endorsing methadone as the treatment of choice for opioid dependence, substantial policy changes have improved its delivery and uptake, whereby it continues to expand at a rate of approximately 14 per cent per year across Australia (Intergovernmental Committee on Drugs, 2004). These changes are threefold. First was the adoption of a treatment strategy which emphasised principles of harm minimisation rather than abstinence. This was encapsulated in the first national methadone policy in 1993, which was based on revisions of the original 1985 national guidelines. In it, the goals of methadone treatment were outlined as being 'to reduce the health, social and economic harms to individuals and the community associated with illegal opioid use' (National Drug Strategy, 1993). Such an objective contrasted markedly with that of most treatment programs in the 1970s and early 1980s, which insisted on clients achieving total abstinence from opioids on threat of punitive sanctions being used against them, such as removal from treatment (Caplehorn & Batey, 1992). This policy shift, which focused treatment on improving the prevention of broader community problems associated with opioid use, removed the focus away from the outcomes achieved by individuals in programs to the effectiveness of the treatment on the overall client population. Allied with this was a reduction in the demands on clients to achieve abstinence, and to do so within a specified time limit; to undergo regular mandatory supervised urine tests to screen for the use of illicit drugs; and to participate in compulsory ancillary treatments, such as counselling. At the same time, there was a relaxation in the criteria for admission into treatment such that younger clients and those who used drugs other than opioids, for example, could access methadone services (Ward, Mattick & Hall, 1998).

The second policy change which increased the attractiveness of replacement therapies to the opioid dependent was a growing emphasis on diversity in the modes of treatment delivery. In 1985, individual general practitioners and psychiatrists were authorised to prescribe methadone in maintenance doses for up to 120 clients (Caplehorn & Batey, 1992). Since that time, these services have been provided either through specialist methadone treatment clinics or as part of individual private practices.
In some states, such as New South Wales, there has also been a mix of private and public sector services, where private practitioners prescribe methadone while operating out of public clinics or hospitals. As suggested earlier, private sector participation in methadone treatment has rapidly expanded to the point where it now accounts for the bulk of methadone maintenance services in Australia, particularly in New South Wales. Since the launch of the National Illicit Drug Strategy in 1997, there has been an increasing emphasis placed on attracting general practitioners to methadone prescribing by encouraging them to treat clients in their own consulting rooms. Methadone dispensing is then undertaken by either local pharmacists or the nearest hospital. Such decentralised ‘mainstream’ community based treatments are attractive to clients because it enables them to avoid both the stigma associated with attending a methadone clinic as well as the temptations created by encountering other drug users. It also enables them to access treatment in their local community, a most important element in deciding to enter treatment for those living in regional and rural areas.

The final policy initiative that has been associated with the expansion of opioid replacement therapy in Australia is the increasing use of alternative pharmacotherapies to methadone. Buprenorphine, marketed as Subutex, is a sublingual analgesic tablet that was registered for use as an opioid substitution therapy in Australia in November 2000 and introduced as a treatment in August 2001. Unlike methadone, buprenorphine is a partial, not a full, opioid agonist, which means that it has a decreasing opioid effect with increasing doses beyond a plateau of potency. This makes it comparatively safer than methadone inasmuch as the risk of overdose is reduced, particularly when additional opioids are taken or when it is taken by other people. The partial agonist effect also means that the tendency toward chronic physical dependence created by opioids such as methadone is also lessened, making withdrawal from it easier. Finally, buprenorphine’s long-acting duration means that it is also suitable for alternate-day dosing, making it much more convenient for clients (Intergovernmental Committee on Drugs, 2004; Mattick, Oliphant, Ward & Hall, 1998). For these reasons, together with the absence of the kinds of side-effects commonly reported by clients using methadone (Goldsmith,
Hunt, Lipton & Strug, 1984), buprenorphine has the capacity to increase the attractiveness of opioid replacement therapy among out-of-treatment illicit opioid users.

**Future Directions for Research in Contemporary Opioid Replacement Therapy**

The evolution of opioid replacement therapy in Australia described in the previous section has several implications for future evaluations of its effectiveness. The expansion of private sector treatments, either through the establishment of specialist clinics servicing large numbers of clients or small-scale community based treatments provided by a diversity of service providers, has resulted in a complex service environment. Moreover, the nature of interaction between the public and private sectors, which varies across state jurisdictions, increases this complexity and invites questions about how clinical responsibilities between the sectors will be structured and shared and how the costs of treatment will be borne. While there exists national policies on methadone treatment (National Drug Strategy, 1998) and buprenorphine treatment (National Drug Strategy, 2002) which outline recommended treatment protocols, these are guidelines only and do not have any legislative effect. The provision of treatment to clients is dependent upon state laws, and providers have the power to arrange services such as dose levels, takeaway doses and urine tests as they wish. Combined with the lack of a formal accreditation process to ensure that both private and public service providers maintain appropriate clinical standards, the means by which opioid replacement therapy is delivered can therefore vary considerably across and within treatment sectors and jurisdictions.

Despite this diversity in the organisation of treatment, the overwhelming bulk of research into the effectiveness of opioid replacement therapy has examined the effect of services provided in specialist clinic environments (Ball & Ross, 1991; Darke et al., 2005; Hubbard, Marsden, Rachal, Harwood, Cavanaugh & Ginzburg, 1989; Simpson & Sells, 1982). As such, little heed has been paid to the impact of the clinical settings in which services are offered. In Australia, for example, there is little research available which documents the differences in the structure and operation of private and public sector programs and compares their effectiveness. One notable exception is a study that
compared the nature of the treatment delivered and outcomes achieved in three large private clinics with three large public sector counterparts (Bell et al., 1995). The key service differences between these clinic types were that the private clinics charged dispensing fees of up to $50 per week per client; had more frequent medical consultations; provided no formal counselling; had lower staff-patient ratios; and provided more takeaways. While clients in both the public and private clinics achieved substantial reductions in their heroin use, crime participation and HIV risk-taking behaviour along with an increase in their social functioning, there were significant differences in the quality and effectiveness of the treatment delivered within each of the different clinics. In particular, there were marked differences among the three private clinics in their standard of care. The least effective private clinic, which had the highest rates of client heroin use and the poorest client retention, had 'chaotic' management, poor staff-client relationships, little communication among staff, a low staff-to-client ratio and poor clinical record-keeping. As such, apart from the effect of methadone dose, this evaluation demonstrated that aspects of clinic organisation and functioning, particularly staff and client interactions, are an important determinant of treatment effectiveness.

There has also been very little research in Australia into the effectiveness of treatment provided in community settings, particularly that involving general practitioners and retail pharmacies. To date, only one comprehensive evaluation of community methadone treatment exists, and this was conducted in metropolitan Victoria, a state which has some unique service delivery features that distinguish it from other Australian states (Lintzeris et al., 1996). For example, the great majority of Victorian clients are prescribed methadone by GPs operating privately in the community and engaged in general primary care while a sizeable proportion of prescribing in NSW is conducted by psychiatrists who often work in settings exclusively for methadone clients. Further, in Victoria, clients are allowed only one takeaway dose per week (Ezard, Lintzeris, Odgers, Koutroulis & Muhleisen, 1999) while clients in New South Wales are allowed up to four (New South Wales Health Department, 1999). In their approach to methadone treatment, psychiatrists tend to take
a more interventionist approach with clients than GPs, requiring more frequent consultations and urine testing and offering fewer takeaways (Commonwealth Department of Human Services and Health, 1995). While it is difficult to assess the impact on treatment outcomes of these differences in service provided by general medical practitioners versus specialists, there is evidence to suggest that greater numbers of takeaway methadone doses increase rates of client retention in treatment (Pani, Pirastu, Ricci & Gessa, 1996).

Regardless of these anomalies, an examination of the Victorian findings is nonetheless instructive. In it, 116 methadone prescribers, 188 pharmacists and 195 clients were surveyed and interviewed about their satisfaction with issues of client access to treatment; client-service provider relationships; the provision of other health-related services; treatment fees; dose levels; takeaway doses; transfers to other dosing sites; and urine testing (Ezard et al., 1999; Lintzeris et al., 1996). In terms of clinical outcomes, 85 per cent of clients reported a reduction in their heroin use and 60 per cent indicated less involvement in crime since joining the program. According to these standard indicators, then, community treatment appears to be as effective as its clinic based equivalent.

In addition, however, there emerged significant findings peculiar to the mode of community treatment. With 72 per cent of clients receiving the unemployment benefit and the mean proportion of weekly income spent on treatment being 19 per cent, three-quarters of the clients reported experiencing problems in paying for their treatment. A little over 12 per cent reported having discontinued their treatment, either voluntarily or involuntarily, because of outstanding fees. Almost 46 per cent of clients reported that treatment at pharmacies was ‘too public’ and that confidentiality needed to be increased. Overall, while 72 per cent of clients and 88 per cent of prescribers reported being either satisfied or very satisfied with methadone treatment delivered in community settings, 39 per cent of pharmacists reported being dissatisfied. The reasons for dissatisfaction included difficulties and disruptions created by the dispensing process; the unwillingness of clients to commit to treatment or to take responsibility for themselves; and difficulties collecting fees for treatment (Lintzeris et al., 1996). Delays encountered
through supervising clients' ingestion of buprenorphine, which has to be held under the
tongue for up to five minutes in order to be absorbed, has also been reported by
Victorian pharmacists as a disruption in a busy pharmacy environment (Lintzeris, Ritter,
Panjari, Clark, Kutin & Bammer, 2004). Perhaps reflecting their dissatisfaction with
client involvement in treatment, 53 per cent of pharmacists compared with only 9.3 per
cent of prescribers in the 1996 evaluation identified client abstinence from drugs as
indicative of a successful treatment outcome (Lintzeris et al., 1996). While client
retention in treatment was not measured in this study, these findings nonetheless
suggest that aspects of the treatment format, such as the fee structure, protocols to
protect client confidentiality and the orientation of providers to the service delivery
process, have an important role to play in the nature of both client and provider
engagement in community based opioid replacement therapy.

Considered in general terms, the findings from these few Australian studies
indicate that the effectiveness of opioid replacement therapy as it is currently structured,
where private modes of delivery predominate, is dependent on clients' ready access to
not simply a pharmacotherapy of their choice but a treatment that is delivered
consistently and to a standard where its therapeutic capacities can be optimised. An
effective treatment by this definition is therefore one that aims to not only improve
client functioning but also maximise client involvement in treatment by ensuring that
the main components of the treatment milieu are appropriate to the greatest range of
needs of those who seek help. Where there are differences in the format and operation
of the various treatment modalities, as have been demonstrated, determining how the
client population can be best matched to them and the degree to which those modalities
can qualitatively vary before treatment effectiveness is impeded makes evaluations of
the treatment process an essential feature of the next generation of research efforts into
opioid replacement therapy. Before the status of research on this topic can be
considered more fully, however, it is necessary to consider briefly the relationship
between process and outcome indicators of treatment effectiveness in opioid
replacement therapy and the moderating influence of client characteristics. These are
reviewed in the following section. It is important to note that the review is meant to be indicative rather than comprehensive.

Assessing Treatment Effectiveness in Opioid Replacement Therapy: An Overview

Outcome Effectiveness

When approached as a maintenance treatment rather than a treatment designed to enable individuals to become abstinent from all drugs, the effectiveness of opioid replacement therapy has been assessed according to its capacity to reduce the social and individual harm associated with illicit opioid use. When the baseline for comparison is the outcomes of illicit opioid users who receive no treatment, methadone maintenance treatment, the most widely evaluated opioid replacement therapy to date, has been consistently shown to produce improvements in client functioning in several domains. Comprehensive reviews (e.g. Ward et al., 1988; Ward, Mattick & Hall, 1992) have identified the following main outcome effects of methadone maintenance therapy. First, both randomised controlled trials and observational studies have shown that it results in reductions in client heroin use and crime participation (e.g. Mattick et al., 2004; Ross et al., 2004). Second, case control studies indicate that methadone maintenance therapy is associated with a reduction in the spread of HIV and other blood-borne infectious diseases transmitted through needle-sharing injection practices (e.g. Chitwood, Griffin, Comerford, Page, Trapido, Lai et al., 1995). Finally, observational studies reveal that the risk of fatal overdoses related to opioid use is lessened for methadone maintenance clients (e.g. Gearing & Schweitzer, 1974). To date, reviews of research on the effectiveness of buprenorphine indicate that, when used as a maintenance treatment in either clinic or community settings, it is at least as effective as methadone maintenance therapy in reducing illicit drug use and, by default, the personal and social harms that flow from it (Simons, Matheson, Bond, Inkster & Ludbrook, 2005; Raisch, Fye, Boardman & Sather, 2002).
The Influence of Client Characteristics

The outcomes described above can only be obtained once clients are retained in treatment beyond a threshold time when improvements in their functioning can be regarded as significant. Indeed, while the nature of the association is complex, there is substantial evidence to suggest that length of time in treatment is related to positive in-treatment (Ball & Ross, 1991) and post-treatment (Simpson, 1979, 1981) client outcomes. In order to maximise retention, the main elements of the treatment process need to be appropriate to the needs of the client population. Conversely, however, client characteristics can also have a moderating effect on the operation of these treatment variables. Clients with more severe problems may be more likely to self-select for treatments that offer more support, which in turn shapes the way those forms of treatment are structured and delivered. For example, unemployed or low-income clients may elect to remain with public sector clinic based treatments indefinitely because they are free, but in a policy environment of cost containment where restrictions are placed on the provision of extra treatment places, this may impact on the capacity of such clinics to accept new clients or clients with different needs. In general, reviews of the main client characteristics which impact on the effectiveness of treatment (e.g. McLellan, 1983) indicate that demographic factors such as age; poly-drug use; psychological problems, including depression, anxiety and personality disorders; and a lack of social support impede client responses to, and retention in, treatment. More recently, client motivation to change and readiness for treatment have also been recognised as exerting an influence on the treatment process (Simpson, Joe, Rowan-Szal & Greener, 1995).

Monitoring the incidence of client characteristics such as these is important in ensuring that individual clients can be matched to services provided by suitably qualified and experienced practitioners. This is particularly important in community based treatments, where clients with complex needs may present to service providers who are not specialists in the management of psychiatric and other substance abuse related problems. In Australia, attempts to circumvent problems in this regard have resulted in proposals to reformulate the role of the public sector (Commonwealth
Department of Human Services and Health, 1995). Under such a plan, public clinics would become the access point for all new entrants to treatment, clients with more complex needs and behavioural difficulties would be retained in them and more stable clients would be referred to community providers. The public sector would also provide specialist services for clients, such as counselling, as well as liaison and consultation support to providers operating in the community. While this recommendation has been incorporated into the treatment service plans of some jurisdictions (e.g. New South Wales Health Department, 2000), there is currently no published information available to indicate how different client groups are being managed across the sectors. A census of 121 methadone maintenance clients treated in general practice environments in New South Wales in the mid-1990s revealed that on measures of patient age, duration in treatment, HIV status and prison history, the profiles of clients in the community sector were comparable with those from other treatment environments (Byrne & Wodak, 1996). Similarly, in a Canadian study investigating patient characteristics following the expansion of methadone maintenance therapy in Ontario, the proportion of unstable clients who elected to transfer from a clinic to a community based environment was found to be similar to the proportion who remained in clinic treatment (Brands, Blake & Marsh, 2002). Such findings emphasise the importance of maintaining continuity of care across treatment sectors for clients with special needs.

Process Effectiveness

Implicit in the above discussion is the idea that client retention in treatment is a function of an interaction between the types of individuals in treatment and attributes of the treatment itself. These attributes include the structure and content of the treatment, which encompasses the various services provided, as well as the way the treatment is delivered, which refers to its program of operation. Evaluated individually yet considered together, these attributes, or indicators, provide a measure of the effectiveness of the overall treatment process. In a landmark evaluation of six clinic based methadone programs in North America, Ball and Ross (1991) sought to comprehensively define the relevant attributes that should be assessed in any drug treatment program and to demonstrate how they impact on clinical outcomes. They
conceptualised the treatment process according to two factors: programs and services. Program indicators broadly encompassed clinic policies; the nature of client-staff relationships; and the administration and organisation of the clinic. Service indicators included dosing arrangements; and ancillary services, such as counselling, medical care, vocational assistance and urine testing. This design was successful in highlighting the relationship between specific treatment variables and client outcomes. As such, it served as the influence for the organisation of the following discussion of process indicators of treatment effectiveness in the current opioid replacement therapy environment.

**Indicators of Treatment Process Effectiveness**

The expansion of Australian opioid replacement therapy has occurred through the incorporation of a greater range of service formats; a relaxation in treatment entry requirements and lowered expectations of clients once in treatment; and the availability of new pharmacotherapies. It is unclear how this combination of factors will impact on client retention rates and, therefore, treatment outcomes in the longer term. While the convenience of community dosing, accessibility of maintenance programs and availability of a range of substitution treatments could be expected to increase retention rates, this is not self-evident; some elements of these changes, including an associated increase in treatment places, may reduce service demand. The expansion of the public methadone maintenance program in the Australian Capital Territory in 1996 to include private community dispensing is a case in point. The initial improvement in the retention of clients in the service was not sustained. By 1998, between one-quarter and one-half of clients were dropping out before stabilisation at six months and many were making several attempts at treatment (Bammer, Battisson, Ward & Wilson, 2000). The sources of client attrition in this program were not investigated in the study, but in the first instance they point to changes in elements of the treatment process. A review of those most relevant to the current Australian treatment environment, using the heuristic provided by the Ball and Ross (1991) study referred to above, may be informative in highlighting their impact.
Program Policy: Treatment Orientation

Prior to the adoption of a harm minimisation strategy in the mid-1980s, the goal of most Australian methadone programs, like that of their counterparts in other Western countries, was assisting clients to become abstinent of all drugs, including methadone. In concert with this, program rules usually stipulated strict time limits on treatment, defined maximum doses of methadone and outlined protocols for the expulsion of clients who continued to use illicit drugs while in treatment. The public policy decision to adopt a maintenance orientation to treatment, thereby relaxing these rules, was based on broader public health concerns about limiting the spread of HIV among illicit drug users. Its acceptance among service providers, however, has not been universal (Kahn, 1992).

A possible reason for this is the different assumptions these two approaches make about the nature of dependence. Those who view opioid dependence primarily as a physiological addiction resulting from an opioid receptor system defect see long-term methadone maintenance as the key to providing relief from the symptoms of dependence as it is a biologically based deficit that is considered to affect the behaviour and emotional stability of the affected individual (e.g. Dole & Nyswander, 1965). Providers who instead consider opioid dependence to be the consequence of an attempt to manage psychological problems through drug use are likely to consider treatments such as methadone to have a time-limited usefulness and to be only an adjunct to services aimed at eliminating an individual’s psychopathology, such as counselling and psychotherapy (e.g. Cole & James, 1975). Advocates of biological theories of dependence therefore see the goal of opioid replacement treatment as successful maintenance on methadone or an alternative opioid substitute while those favouring psychosocial theories consider the achievement of abstinence from all drugs as indicative of a successful treatment outcome. This said, support for either maintenance or abstinence oriented treatment is not necessarily indicative of a provider’s adherence to the theory of dependence with which either is typically related. Some individuals may advocate maintenance treatment simply because it represents a pragmatic response to a social problem (Bell, 1998).
Programs with an abstinence orientation may also be attractive because their aim accords with the moral goal of the criminal justice system, with which many opioid dependent people are involved. Like the criminal justice system, opioid replacement programs aimed at abstinence seek to regulate and control the behaviour of socially disruptive individuals in order to effect a cure of the problem behaviour (Weppner, 1979). Under such a system, simply providing dependent individuals with relief or respite from a cycle of drug seeking is not seen to address the consequences of their inappropriate volitional acts. Support for this proposition was demonstrated by Caplehorn and colleagues (Caplehorn, Irwig & Saunders, 1996b), who found that treatment staff who personally disapproved of illicit drug use and sanctioned societal retribution for it tended to be committed to abstinence-oriented rather than maintenance-oriented treatment policies.

Abstinence based treatment programs have been found to have poorer client retention than maintenance treatments over and beyond the differences in treatment tenure implicit in the two policy positions (Ball & Ross, 1991). A survey of six public methadone programs in Sydney covering the period 1989 to 1992 showed that clients in clinics with an orientation towards abstinence were at an exponentially increased risk of premature discharge with each increasing degree of commitment to abstinence by the staff in such clinics (Caplehorn, Lumley, Thomas & Irwig, 1998). A study of private prescribers in Sydney surveyed over the same period found similar results, with clients on higher doses at particular risk of failure to stay in treatment (Caplehorn, Irwig & Saunders, 1996a).

Despite a national policy endorsing maintenance treatment for opioid dependence and research demonstrating it to be the more effective approach in maximising client retention, there is evidence that many service providers, particularly in the community sector, are continuing to operate with an abstinence orientation to treatment. As noted earlier in this chapter, the 1996 Victorian evaluation of community methadone services found that 53 per cent of pharmacists believed client abstinence from drugs to be indicative of a successful treatment outcome (Lintzeris et al., 1996). In the United Kingdom, which has a comparatively longer history of community based
substitution pharmacotherapy, there have been reports that GPs are reluctant to accept the notion that the length of maintenance treatment may be unlimited and that clients are not necessarily motivated to move to abstinence (Merrill & Ruben, 2000; Watson, 2000). As a consequence, many GPs in Edinburgh, for example, have set quotas of clients and 43 per cent have adopted a policy not to prescribe to the opioid dependent in the future (Merrill & Ruben, 2000). Similarly, in Germany, a 1996 survey of 247 GPs revealed that half of them supported abstinence-oriented policies and one-quarter supported a punitive societal response to illicit drug use (Gerlach & Caplehorn, 1999).

These attitudes and beliefs are of concern inasmuch as they have a potentially corrosive effect on the working relationship between practitioners and their clients, particularly where staff working within the same clinic hold contradictory views of the official treatment policy. It has been shown that staff with greater training and knowledge of maintenance treatments are less likely to adopt abstinence-oriented values in working with their clients (Caplehorn, Hartel & Irwig, 1997). However, other commentators note that service providers with a biomedical background often struggle against the received training of their discipline that they can impel change in their clients and that opioid dependent clients will take advantage of opportunities to reduce their dependence (Bell, 1998). Since the conduct of the Australian research cited above (Caplehorn et al., 1998; Caplehorn et al., 1996a; Lintzeris et al., 1996), training programs addressing these issues have become mandatory for newly enrolled service providers working in opioid replacement therapy in Australia. The impact of their success or otherwise is generally unknown. To date, it is still unclear to what degree service providers operating in a policy environment advocating maintenance are ambivalent about the value of such an approach and, if so, how they manage this in their everyday relationships with clients.

*Nature of Client-Staff Relationships*

Underpinning the issue of treatment philosophy is a broader one about the quality of the relationship between service providers and clients. In large-scale clinic evaluations, it has been noted that an important factor in improved clinical outcomes is not the range
of services provided or the ratio of staff to clients but whether therapeutic relationships exist between treatment staff and clients (Ball & Ross, 1991; Bell et al., 1995). Despite this observation, there has been little subsequent research aimed at defining the constitutive features of such relationships in opioid substitution therapy or describing how they are maintained.

The focus of work in this area has been the identification of both provider and client roles in treatment and a description of the processes influencing their management. In a two-year study examining the delivery of counselling and support services in both public and private sector methadone clinics in London, Lilly and colleagues (Lilly, Quirk, Rhodes & Stimson, 2000; 1999) found that both treatment staff and clients perceived service providers as occupying multiple and often conflicting roles. The researchers concluded that this stemmed from dynamic tensions related to the staff’s requirement to balance the needs of individual clients against their responsibility to enforce public health regulations related to the provision of methadone. For example, staff who stressed the therapeutic value of building an alliance with a client in a ‘counsellor’ role felt limited in exploring issues of drug use because their responsibility as a ‘gatekeeper’ or ‘disciplinarian’ was to monitor the client’s compliance with program rules around such matters. Moreover, these tensions manifested not just in the types of roles assumed by staff but in the great number of roles that staff felt required to assume due to resource constraints in the agency (Lilly et al., 1999). Antagonism caused by these differing positions was managed by staff negotiating treatment decisions with clients and being aware of the need for consistency in their approach to problems. Clients, on the other hand, managed the tensions through constant monitoring of the behaviour of staff in order to determine whether they could trust them. Both staff and clients noted the importance of the time required to build an effective therapeutic relationship (Lilly et al., 2000).

This research provides valuable insights into the dynamics of an effective treatment relationship in opioid replacement therapy. First, it points to the importance of clients having control over decisions about their treatment and clinicians respecting their choices within the limits of the regulations even if they may not personally agree
with them. This transmits to clients a recognition and validation of their needs. Second, this study suggests that service providers need to be conscious of the manner in which they respond to clients insofar as the reactions of clients are based on the perceived integrity or reliability of the provider. In this way, providers model for clients appropriate forms of engagement in the relationship. Finally, the research indicates that benefits for both parties obtained from a productive client-provider relationship are related to their frequency of contact and their length of involvement.

These results represent a considerable challenge to clinicians who have had little experience associating with the drug dependent, particularly in the early stages of the treatment relationship when clients may not yet have stabilised on their dose or become accustomed to the rituals involved in the everyday life of the program. They also provide a challenge at times of client relapse, when there is likely to be dissonance between the choices clients make for themselves and the behaviours practitioners have come to typically expect of those individuals. Building a successful treatment alliance under such circumstances is especially confronting for providers who work alone, such as those in the community sector. General practitioners and pharmacists who have not worked with illicit drug users have been frequently reported as having negative attitudes towards them (Abouyanni, Stevens, Harris, Wickes, Ramakrishna, Eng et al., 2000; Matheson, Pitcairn, Bond, van Teijlingen & Ryan, 2003; Merrill & Ruben, 2000; Sheridan, Strang, Taylor & Barber, 1997), though these decrease as they gain experience in working with the population (Matheson, Bond & Mollison, 1999). This is partly attributed to a lack of self-confidence in their ability to manage the issues presented by this group of clients (Abouyanni et al., 2000; Bell, 1998; Merrill & Ruben, 2000) and partly a reflection of a shared community perception of injecting drug users as dangerous pathological criminals (Ross & Darke, 1992). More specifically, such clinicians’ concerns relate to the emotional adjustment issues that clients may present with in the form of manipulative behaviours and threats of violence and aggression against staff. Accordingly, clients prescribed and dispensed methadone in primary care settings appear to have ambivalent attitudes to such providers based on their perception of them as being uninterested in, unsympathetic towards and impatient with illicit drug
users (Bennett & Wright, 1986; Fountain, Strang, Griffiths, Powis & Gossop, 2000; Gabbay, Smith & Dawkes, 1996).

Given what is known about the components of successful client-staff relationships and their management as well as the likely attitude changes required by new entrants to the treatment of drug dependency, there remains a need to detail how treatment decisions are negotiated between providers and clients, particularly under emotionally stressful conditions. There is also scope for investigating how clinicians manage the inevitable disappointments that arise when provider and client goals for treatment appear to differ and commitment to the treatment relationship is threatened. Such a program of research would assist providers to feel more confident of their capacity to handle the stresses of working with people with complex presentations.

Administrative and Organisational Arrangements: Treatment Fees

The Australian studies reviewed earlier in the chapter (Bell et al., 1995; Ezard et al., 1999; Lintzeris et al., 1996) indicate that treatment fees negatively impact on client retention in treatment through either clients’ voluntary termination from programs or their expulsion by service providers for lack of payment. They also accord with findings of evaluative research into similar models of treatment in other countries. Dispensing fees, for example, have been found to have an adverse impact on low income clients’ access to, and retention in, North American treatment programs (Booth, Corsi & Mikulich-Gilbertson, 2004; Borisova & Goodman, 2004; Britton, 1994; Maddux, Prihoda & Desmond, 1994) as well as community based programs in the United Kingdom (Bennett & Wright, 1986).

The issue of dispensing fees has also raised concerns about its impact on a number of other client behaviours. For those who attempt to remain in treatment, these include an increase in the sale of their takeaway doses into the illegal drug market and continued, albeit lower, involvement in crime in order to finance their care. For those who drop out of treatment, there is the risk of a return to a more dangerous lifestyle. For example, one longitudinal study in North America found that clients who had dropped out of treatment after losing a funded place in a methadone maintenance program were
more likely to use heroin, share needles and engage in high-risk sexual practices more frequently at a one-year follow-up than clients continuing to receive subsidised treatment (Britton, 1994).

Clearly, therefore, a failure to consider the financial costs of treatment to clients can result in an overestimation of its benefits. While some service providers believe that a client’s preparedness to contribute to the cost of their treatment is an indicator of their commitment to it and, as such, is likely to lead to a better outcome (Lintzeris et al., 1996), it remains unclear at what level costs become a barrier to client engagement in treatment. A recent evaluation of clients’ willingness to pay for treatment indicates that clients regard travel time and waiting time as costs that are incurred in addition to treatment fees and that these are extra rationing devices in their decision to attend treatment (Borisova & Goodman, 2004).

Dosing Arrangements

There is ample evidence that increasing doses of methadone are associated with reduced symptoms of withdrawal, drug craving and, therefore, reduced heroin use in treatment and increased client retention (see Ward et al., 1988, for a review). While the association is more complicated with buprenorphine because it is a partial agonist, there is a clear linear dose-response relationship for methadone. Despite evidence for the use of higher doses, there are reports that significant numbers of GPs are prescribing doses below the recommended range (D’Aunno, Folz-Murphy & Lin, 1999; Lintzeris et al., 1996; Matheson et al., 2003). Alternatively, others have been found to over-prescribe by as much as twice the daily recommended dose, increasing the risk of client overdose and the diversion of methadone into the black market (Strang & Sheridan, 2001). One possible explanation for these seemingly inappropriate prescribing practices is the greater involvement of clients in decision making around dose levels. For example, while the average methadone dose for clients in community based treatment in Victoria was found to be 41 milligrams and the most frequently reported dose was 30 milligrams, 75 per cent of those sampled indicated that their dose was ‘just right’. This said, 48 per cent of clients believed their commencing dose was too low (Lintzeris et al.,
1996). On the basis of the available evidence, it is unclear to what degree clients are involved in determining their dose levels and how they make decisions about what their doses should be. Given that clients transferring from methadone to buprenorphine are at risk of experiencing some physiological discomfort until dose equivalence is achieved (Lintzeris et al., 2004), the satisfactory negotiation of dose levels may have a reasonable impact on client decisions to persist with treatment.

In addition to the issue of setting an adequate dose, there is the manner in which the dose is delivered. The dispensing environment needs to be safe such that clients are free from harassment by others and intoxicated clients are not put at risk of overdose. Individual doses also need to be dispensed fairly and in a way that preserves client confidentiality. There is little research available on the degree to which practitioners adhere to these practices, particularly in the community sector, and the effect this has on client responses to treatment. Initial findings from the 1996 Australian evaluation of community dispensing found that 32 per cent of pharmacists would provide intoxicated clients with their usual methadone dose. The reasons provided for this practice included a belief that the pharmacological dangers would be minimal; a relationship of minimal contact with the prescriber; a fear of retribution from clients for refused doses; and a lack of knowledge about the interactive effect of different substances and methadone (Koutroulis, Kutin, Ugoni, Odgers, Muhleisen, Ezard et al., 2000; Lintzeris et al., 1996).

The issue of fairness in community dispensing has been associated with the time taken to be dosed. Just over 41 per cent of clients in the 1996 Victorian evaluation reported that other customers are given priority over methadone clients in pharmacies and that they have to wait for up to 30 minutes to be dosed in some instances. The attributions made by the respondents for this were that pharmacists regarded clients as 'scumbags', 'thieves' and 'junkies' (Lintzeris et al., 1996). With regard to the issue of confidentiality, as revealed earlier in this chapter, almost 46 per cent of Victorian community based clients described their treatment at pharmacies as 'too public'. More specifically, confidentiality was considered to be threatened by other clients being able to view personal details recorded on dosing registers and by clients being dosed in view of other customers in the pharmacy, who could potentially include friends and family.
(Lintzeris et al., 1996). Similar concerns have been reported in Scottish community dispensing programs (Neale, 1999). How clients respond to these experiences, to the extent these problems are encountered in similar dosing situations, remains to be determined.

Ancillary Services

Ancillary services are services provided in addition to pharmacotherapy, such as counselling, general medical care and vocational rehabilitation. Ball and Ross (1991) provided evidence that programs with a higher level of treatment services, such as counselling and medical care, tended to have improved client outcomes, such as decreased criminal activity and heroin and cocaine use. These services are not standard components of opioid replacement therapy in Australia. However, counselling can be considered to be an integral component of the case management function performed by drug and alcohol workers in public sector clinics. By this definition, counselling includes mediation for clients seeking to liaise with other service providers, particularly in times of crisis; the assessment of new clients; brief follow-up contacts with continuing clients; education and information provision; and therapeutic interventions for those seeking assistance with psychological problems. With its focus on the psychosocial adjustment of clients to treatment, counselling in this form can be argued to improve upon the rehabilitative outcomes of the opioid substitute itself. With regard to interventions such as medical treatment, proponents of community based prescribing argue that the increasing involvement of GPs strengthens the likelihood that clients' general health needs will be addressed (Carnwath, Gabbay & Barnard, 2000). The effectiveness of these services in retaining clients in the current Australian treatment environment is yet to be determined.

Assessing Treatment Process Effectiveness: Obtaining the Client's Perspective

As has been shown, outcome success in opioid replacement therapy has been traditionally measured by examining the influence of both client characteristics and treatment processes on changes in client health and social adaptation. While these are
important indices for evaluating program effectiveness, they do not provide a complete picture of treatment outcomes. In such research, clients are typically conceptualised as either passive recipients of treatment or, where the influence of their profile is important, only select personal characteristics are assessed and the results are reported in aggregate form.

Over time, however, there has been a gradually increasing recognition that clients' perceptions of, and attitudes to, the treatment experience exert an important influence on outcomes (Conners & Franklin, 2000; Williams, 1994). Explorations with clients of the activities they engage in on a day-to-day basis in receiving treatment have come to be seen as useful in evaluating client experiences of the treatment process and their likely commitment to them. Such research highlights that clients have elaborate reasons for engaging in opioid replacement therapy, are active participants in the treatment world and are capable of successfully resisting attempts aimed at controlling them through the treatment regimen.

A considerable proportion of the research that has focused on client attitudes to opioid replacement therapy generally has shown that maintenance programs are regarded as valuable by clients currently in them (Mavis, DeVoss & Stoffelmayr, 1991; Neale, 1998). In particular, clients value the ability of opioid substitutes to reduce their illicit drug use, decrease drug-related harm and lessen their reliance on crime (Fischer, Chin, Kuo, Kirst & Vlahov, 2002; Neale, 1998). Never-in-treatment illicit drug users are reportedly deterred from accessing opioid replacement therapy for programmatic reasons, such as a lack of treatment spaces or a lack of income to fund treatment costs (Farabee, Leukefeld & Hays, 1998). Of those who choose to enter opioid replacement therapy, their motivations may include short-term goals such as time out from the stresses of pursuing a drug-using lifestyle; getting their habit under control; reducing the risk of contracting HIV; and testing out their ability to engage in longer-term treatment (Koester, Anderson & Hoeffer, 1999).

There have also been studies of client attitudes toward specific aspects of treatment. Analyses of the efficacy of methadone indicate that clients frequently
experience a range of unpleasant physical side effects from it, including body aches, lethargy and nausea (Fischer et al., 2002; Goldsmith et al., 1984; Koester et al., 1999; Neale, 1998). Findings from attitudinal research into the provision of concurrent ancillary services in opioid replacement therapy, such as vocational rehabilitation programs and counselling, shows that clients regard them as worthwhile and necessary (Atlas, 1982; Jones, Power & Dale, 1994; Mavis et al., 1991; Neale, 1999). With regard to service delivery issues, a variety of conflicting views have been expressed by clients about whether the rules of engagement for various aspects of treatment, such as dosing times and locations, are appropriate and whether they are enforced too strictly and punitively (Fischer et al., 2002; Neale, 1999). Finally, client attitudes to treatment staff have been found to be generally negative, with service providers, particularly in the community sector, viewed as patronising, ignorant, disingenuous and uninterested in illicit drug users (Bennett & Wright, 1986; Fischer et al., 2002; Fountain et al., 2000; Gabbay et al., 1996). Accordingly, this tends to mirror the results of research discussed earlier in the chapter, where providers in this sector have been found to have negative attitudes to clients. Considered overall, these findings indicate which components of treatment clients are likely to make greatest use of and which services have fulfilled their needs.

A more specific form of attitudinal research that has been argued to have relevance to clinical outcomes concerns client satisfaction with various elements of the treatment process (Carr-Hill, 1992). The assessment of client satisfaction differs from the evaluation of client attitudes inasmuch as satisfaction judgments are a dynamic measure of changes in the client’s experience of treatment while attitudes tend to be stable beliefs reflecting a consistent response to a particular issue (Chappel, 1992). Further, client satisfaction judgments are capable of revealing the degree of acceptability of a range of aspects of service, not simply which ones clients consider relevant or useful. As such, they are considered an important source of client feedback in quality assurance efforts aimed at ensuring good clinical practices (Draper & Hall, 1995). The degree to which client satisfaction assessments have been conducted in
Client Satisfaction with Opioid Replacement Treatment

opioid replacement therapy and the adequacy with which they have achieved their aims will be examined in the next chapter.

Conclusion

This chapter has described the development of the current system of opioid replacement therapy in Australia. Its structure and functioning has been shown to be highly varied, with differences existing within and between the public and private sectors in both clinic and community based formats. Together with an additional level of diversity across state jurisdictions, these elements are considered to have resulted in a highly complex service environment. Despite this variation in service modalities, most research into the effectiveness of opioid replacement therapy has been based on clinic models of treatment. As such, elements of the treatment process pertinent to different settings, such as the newly developed community sector, have been relatively neglected in assessments of treatment effectiveness. Using a well-known evaluative framework for classifying treatment process indicators, a review of contemporary opioid replacement therapy in Australia highlighted the following core issues as requiring evaluation:

- Provider attitudes towards harm minimisation principles in general and abstinence based treatment policies in particular;
- Provider and client attitudes to staff-client relationships in opioid replacement therapy and their management;
- Client attitudes toward treatment fees and their management;
- Client attitudes toward the negotiation of dose levels;
- Client attitudes toward the management of dosing arrangements; and
- Client attitudes toward the provision of counselling and medical services.

On standard outcome indicators, opioid replacement therapy provided in different treatment environments has been shown to achieve reasonably comparable improvements in client functioning. However, there has been a growing recognition of the importance of retaining clients in treatment and of retention rates being an important
indicator of the attractiveness and, therefore, usefulness of opioid replacement therapy to clients. Given that retention rates are likely to be increased when there is an appropriate match between the structure and functioning of treatment and client needs, the importance of understanding the interaction of these factors is increased. While clients have traditionally been conceived as passive recipients of treatment in most research designs, more recently there has been a recognition that their interpretations of the treatment provided may not accord with the assumptions of researchers and treatment providers. As such, there has been an increasing reliance on obtaining clients’ understanding of their treatment experiences. One form of research endeavour in this regard has been attitudinal surveys, which tend to show the relatively stable evaluative beliefs of clients toward a range of issues concerning treatment services and their delivery. A more dynamic form of evaluation has involved assessments of clients’ satisfaction with the same issues. Client satisfaction has been shown to be useful in assessing the quality of clinical outcomes and service delivery. Its usefulness in evaluating the core concepts in opioid replacement therapy identified above will be explored in the following chapter.
Chapter 3 – Assessing Client Satisfaction with Opioid Replacement Treatment: A Resource Exchange Perspective

Introduction

Since the 1980s, client satisfaction has become an important focus of research in the health care arena because, as well as enabling an understanding of individual experiences of a service, it has been found to promote client compliance with, and retention in, the treatment regime and to assist with the identification of problems in a program (Carr-Hill, 1992; Sitzia & Wood, 1997). Understanding how clients receiving long-term care evaluate their treatment is particularly important because the quality of their care can directly impact on the quality of their everyday life (Locker & Dunt, 1978).

Research specifically addressing client satisfaction with opioid replacement therapy has been scant. As discussed in the preceding chapter, several studies have sought to uncover the attitudes of current (Mavis et al., 1991; Neale, 1998) and prospective clients (Farabee et al., 1998) towards maintenance programs generally and to explore their motivations for treatment (Koester et al., 1999). Client attitudes toward specific aspects of treatment have also been examined (Atlas, 1982; Bennett & Wright, 1986; Jones et al., 1994; Fischer et al., 2002; Gabbay et al., 1996; Goldsmith et al., 1984; Koester et al., 1999; Neale, 1998, 1999). However, none of this research was aimed at assessing client satisfaction per se or examining the effect of these variables on client retention in treatment.

This chapter seeks to outline a comprehensive model for assessing client satisfaction with opioid replacement therapy and to demonstrate how it may be applied in an evaluation of the key elements of treatment highlighted in the previous chapter. It begins with a review of the few studies specifically designed to assess client satisfaction with opioid replacement therapy. The methodological difficulties besetting this research are explored and subsequently explained by reference to current theoretical formulations of the satisfaction construct. A refinement and extension of these theoretical formulations is offered followed by a reinterpretation of the domains of
treatment appropriate for assessments of client satisfaction. The model that results from this analysis aims to show how client satisfaction is the by-product of a series of specific and appropriate resource exchanges between service providers and clients. Finally, a plan for assessing the usefulness of the model in accounting for client experiences of treatment in opioid replacement therapy is detailed.

The Status of Research into Client Satisfaction with Opioid Replacement Therapy

Purpose, Scope and Approach

Currently, approximately a dozen published studies have specifically assessed client satisfaction with opioid replacement therapy. Almost all of them have aimed to identify client and program variables either correlated with or predictive of client satisfaction. As such, client satisfaction has usually been treated as a dependent variable or outcome measure. In only one study has the effect of satisfaction on other client outcomes, such as time in treatment or attitudes, been examined, and this yielded no significant effects (Joe & Friend, 1989). Consequently, most of the following discussion is based on the determinants rather than the consequences of client satisfaction with opioid replacement therapy.

An analysis of the available literature indicates that client satisfaction with opioid replacement therapy has usually been assessed quantitatively with a variety of measures. In the great majority of studies, standardised pre-coded questionnaires allowing clients to respond to questions in a fixed format have been employed. These instruments require clients to rate on a scale their level of satisfaction with each of usually less than eight aspects of treatment, from which a global rating of satisfaction can be tallied. In two instances, the eight-item version of the Client Satisfaction Questionnaire (CSQ), a well-validated and widely used measure of satisfaction developed for use in the broader health care environment, was used (Chan, Sorensen, Guydish, Tajima & Acampora, 1997; Ward, 2000). Others developed alternative, albeit similarly styled, brief assessment instruments specifically for use in a drug treatment context. The Verona Service Satisfaction Scale (De los Cobos, Fidel, Escuder, Haro,
Sanchez, Pascual et al., 2004; De los Cobos, Valero, Haro, Fidel, Escuder, Trujols et al., 2002) and the Treatment Perceptions Questionnaire (Marsden, Stewart, Gossop, Rolfe, Baccus, Griffiths et al., 2000) are two measures developed for such a purpose. In the remaining studies where details were provided, satisfaction was assessed with a few summary questions such as, ‘Are you satisfied with the treatment you received?’ (e.g. Joe & Friend, 1989).

In each study using these structured assessment measures, regardless of the instrument used, at least 80 per cent of the sample reported either high or very high levels of client satisfaction with the overall treatment. This includes research into day and residential treatments (Marsden et al., 2000; Chan et al., 1997); peer and professional drug counselling programs for women (Sanders, Trinh, Sherman & Banks, 1998); clinic methadone programs (De los Cobos et al., 2004, 2002; Joe & Friend, 1989; Kehoe & Wodak, 2004; Ward, 2000); and community based treatments (Gabbay, Clarke, Willert & Esmail, 1999). In the few studies directly reporting satisfaction ratings for broad components of care, such as service provision and staff behaviour, slightly more response variation has been recorded, though the results are still quite positive (De los Cobos, 2004; Marsden, 2000). In total, these findings mirror those of studies investigating client or patient satisfaction in a range of health fields (Stallard, 1996).

The evidence with regard to the influence of various client and program variables on client satisfaction with opioid replacement therapy is mixed. While this may be partly attributed to the lack of consistency with which satisfaction has been operationalised, the results are nonetheless informative. Client socio-demographic variables such as age and gender have been found to have no association with satisfaction judgments (De los Cobos, 2004; Joe & Friend, 1989; Marsden et al., 2000; Ward, 2000) except for specific services, such as counselling, where a positive relationship has been identified for age (Chan et al., 1997; Sanders et al., 1998). Clients with poorer psychological health and fewer social supports have been shown to have higher levels of treatment satisfaction (Chan et al., 1997). However, continued client
heroin use during treatment has been reported to be associated with lower satisfaction (Marsden et al., 2000).

The relationship between client satisfaction and time in treatment has also produced mixed results. In clinic studies, both no relationship (Joe & Friend, 1989) and a positive association (Sanders et al., 1998; Chan et al., 1997) have been shown to exist, although the data from the Joe and Friend (1989) study were gathered from clients who had spent only three months in treatment. In community based programs containing clients with longer treatment histories than in comparable clinic programs, a negative association between client satisfaction and time in treatment has been found (Marsden et al., 2000). This suggests that there may be an optimal duration of meaningful treatment for clients.

With regard to treatment variables, the background of staff has been found to be positively associated with client satisfaction, although the type of background varies, with some clients being more satisfied if staff have professional qualifications (Conners & Franklin, 2000; Joe & Friend, 1989) while others register greater satisfaction if peers are the treatment providers (Sanders et al., 1998). Similarly, the relationship between methadone dose level and satisfaction is mixed, being positive for some clients (Joe & Friend, 1989) and non-existent for others (De los Cobos et al., 2004). Finally, the number of hours per week that methadone is dispensed has been shown to have a positive association with client satisfaction (De los Cobos et al., 2004). Perhaps allied with this, longer waiting times for treatment have been shown to predict lower satisfaction (Marsden et al., 2000).

Areas for Development

These findings are difficult to interpret with confidence. On the one hand, clients across a range of different program types appear to be quite satisfied with treatment to a quite consistent degree. On the other, the factors associated with their satisfaction are often contradictory. While one interpretation of these findings is that they indicate clients are entering programs appropriate to their particular needs, there are a number of reasons to suggest that they are more likely to be an artefact of the survey methodology employed
in each study. These reasons relate to the assumptions about client evaluative processes upon which standardised questionnaires such as the CSQ are based. They are considered in the following discussion.

The results of the available research into client satisfaction with opioid replacement therapy need to be interpreted with caution for two interconnected reasons. First, with only a few exceptions, the clients in these studies were not given an opportunity to provide the reasoning behind their responses to the questionnaires. As such, it is unclear what motivated their evaluations. It is generally accepted that satisfaction judgments are made relative to some kind of standard insofar as a decision regarding one’s satisfaction is the end product of a process of evaluating certain factors bearing on the issue in question (Carr-Hill, 1992). Questionnaire formats such as the ones used in this research do not allow these factors to be discriminated. As such, respondents who felt unable to criticise their treatment for fear of jeopardising it in some way, those who lacked an interest in evaluating their program and those who were happy with the level of care provided, for example, would most likely all have reported being satisfied with treatment. In this way, potentially a wide variety of treatment experiences would be registered as acceptable with only extreme examples likely to result in expressions of dissatisfaction.

Second, assessments of satisfaction are likely to be most meaningful when their referents are clearly defined. Put another way, satisfaction judgments are relevant to a particular treatment context. In most of the reviewed studies, satisfaction was assessed as a generalised and unidimensional construct. An overall satisfaction rating was obtained by summing the responses to individual items on the questionnaire. In all cases, the weighting or importance given to each item was equal. With only a few exceptions, respondents were not able to nominate the items most important to them or to suggest other areas of service or aspects of the delivery of care they felt were valuable or needed improvement. The areas of treatment nominated as significant for evaluation in the questionnaires were assumed to be those of significance to clients. Therefore, few expressions of dissatisfaction were generated and there was a lack of variability in the reported high levels of satisfaction. Stochastically, this lack of
variability results in weak, and potentially spurious, correlations with other variables (Carr-Hill, 1992).

Further, when the context in which clients receive treatment is clarified, which usually occurs through the use of qualitative methods such as in-depth, open-ended interviews, more negative ratings of client satisfaction are often generated (Williams, 1994). For example, in-depth interviews with clients of mental health services in Britain were found to reveal a variety of negative client experiences that were masked in the clients’ responses to the CSQ (Williams, Coyle & Healy, 1998). The results of the 1996 evaluation of Victorian community based methadone programs referred to in Chapter 3 is an apt example of the same issue (Lintzeris et al., 1996). While 72 per cent of clients were found to be either satisfied or very satisfied with methadone treatment delivery in response to a structured questionnaire, their range of responses in subsequent focus groups revealed a wide range of concerns with various aspects of treatment. In summary, only two of the satisfaction studies reviewed above used such methods to draw conclusions about client responses to various aspects of treatment (Conners & Franklin, 2000; Sanders et al., 1998).

Unfortunately, these difficulties in the measurement of client satisfaction with opioid replacement therapy are not resolved simply through the use of a broader range of methodological tools, though the greater use of qualitative data gathering techniques has been advocated by several authors (Stallard, 1996; Williams et al., 1998; Williams, 1994; Carr-Hill, 1992). This is because the value of the data produced on any subject is largely determined by the explanatory power of the conceptual model guiding the research. Little research has been undertaken with the purpose of explaining, as opposed to measuring, the association between satisfaction and client and treatment characteristics because client satisfaction research is frequently undertaken to address practical needs in an organisation, not to build theory. These criticisms of the research into opioid replacement therapy reflect those of the broader literature on client satisfaction, which is that the meaning of the satisfaction concept has not been clearly delineated and, therefore, no adequate theory of its nature has been developed (Williams, 1994; Carr-Hill, 1992). The lack of a generally accepted definition of
satisfaction and of a theory to guide its measurement has thus resulted in a diffuse and unfocussed body of literature on the topic. Moreover, this lack of consistency has been cited as a major difficulty in any attempts to conduct meta-analyses in the area (Hall & Dornan, 1998).

This said, the above findings suggest that expressions of satisfaction are relative and contextual. Therefore, any project aimed at assessing client satisfaction needs to capture the complexity and multidimensionality of the subject implied in these features. In particular, this requires a specification of the component elements underlying client evaluations of treatment and how they work as well as a classification of the domains of care to which they relate. These topics are the focus of the following two sections.

Theoretical Issues in the Assessment of Client Satisfaction

Current Conceptualisations of Satisfaction

In one of the earliest attempts to develop a theory in this area, Linder-Pelz (1982a:578) defined satisfaction as the expression of a ‘positive attitude’ that is based on a combination of clients’ expectancy beliefs about some dimension of treatment and their affective evaluation of it. According to this value-expectancy model, clients’ beliefs about each treatment dimension, or attribute, and their evaluation of it can be multiplied and the products summed to obtain a measure of their satisfaction with a service.

Alternatives to this model were developed in the field of job satisfaction and rely upon the disconfirmation paradigm (Zegers, 1968). With this approach, satisfaction is considered to be a post-experiential attitude that is measured by the degree of disparity between a standard, such as expectations or values, and perceived occurrences. There are three commonly cited types of theory using this paradigm. The first, discrepancy theories, conceptualise satisfaction as the difference between what actually occurs and what is expected adjusted for the importance of what is expected. The second, fulfilment theories, conceptualise satisfaction as the simple difference between what is expected and what occurs unadjusted for how much is desired in the first place. The third, equity theories, conceptualise satisfaction as a function of whether people
perceive they are being treated fairly according to some standard. Unlike the first two theories, equity theories stress the importance of interpersonal rather than intrapersonal comparisons (Lawler, 1973). Most studies of client satisfaction appear to have been implicitly based on these disconfirmation models. Further, they appear to have utilised discrepancy or fulfilment rather than equity principles.

The greatest challenge for models reliant upon the disconfirmation paradigm appears to be the degree to which expectations can account for subsequent satisfaction judgments and how that happens (Williams, 1994; Oliver, 1980). For example, it is possible that clients may not have firmly held or articulated expectations about their care if they are either first-time users of a service or are being subjected to highly technical treatments. Discrepancy and fulfilment models have also been criticised on logical grounds inasmuch as any outcomes that deviate from what was expected do not necessarily result in dissatisfaction. For example, where outcomes are achieved over and beyond what was predicted, there is likely to be a pleasant surprise, not dissatisfaction (Pascoe, 1983). Finally, at an empirical level, expectations have been shown to account for only a small percentage of the variance in subsequent satisfaction judgments (Linder-Pelz, 1982b).

While it seems logically appropriate that expectations would have some role to play in client evaluations, the most parsimonious response to the above criticisms is that the relationship between expectations and satisfaction does not appear to be simple. One possible explanation derived from models of consumer satisfaction in the marketing literature is that expectations are altered or modified in some way during the process of evaluation. Such a modification invokes assimilation-contrast principles drawn from Festinger’s (1957) theory of cognitive dissonance. This suggests that when perceptions of attribute performance, being some aspect of service, differ only slightly from expectations, there is a tendency for people to displace their perceptions toward their expectations. This is known as the assimilation effect. Conversely, there comes a point either side of this range where people can no longer implement this displacement but begin to exaggerate the increasingly large variation between perceptions and expectations. This is the contrast effect. This non-linear conceptualisation of the
relationship between expectations and satisfaction judgments helps to account for why there is so little variance in reported levels of satisfaction.

An earlier model utilising this solution was developed by Anderson (1973) and is shown at Figure 3.1. (Shading has been added to this and all remaining diagrams in this chapter for the purposes of exposition.) The horizontal axis represents the actual or objective performance of some treatment attribute over time. The vertical axis represents the client's perception of it, with perceptions becoming increasingly positive in the top half of the line and increasingly negative in the bottom half. The diagonal axis represents the client's expectations, and these influence perceptions. The dark curved line represents the changes in the client's perceptions as influenced by expectations. When the difference between the client's expectations/perceptions and the actual performance of some treatment attribute is small (represented by the part of the curve encompassing the solid grey area), there is an assimilation effect. In this example, the client lowers or minimises his or her expectations so that they accord with the actual treatment attribute. When the differences are sufficiently large (those parts of the curve encompassing the chequered grey sections), the contrast between expectations and actual performance is exaggerated and dissatisfaction is registered.

![Figure 3.1 Anderson's assimilation-contrast model of satisfaction.](Source: Adapted from Anderson, R.E. (1971). Consumer dissatisfaction: The effect of disconfirmed expectancy on perceived product performance. *Journal of Marketing Research, 10*(1), 38-44.)

A more sophisticated version of this model was developed by Thompson and Sunol (1995). It acknowledges the logical contradiction involved in attempting to
measure the objective performance of some treatment attribute by examining an intrapersonal process where an individual's evaluation of his or her expectations is compared with his or her subjective perception of what actually occurred. Put another way, objective performance is a misnomer as all attribute performance is judged by a client according to his or her perception of it. As such, satisfaction relates to subjective criteria rather than objective measures per se.

Figure 3.2 presents Thompson and Sunol's model. Initial perceptions of the treatment attribute are represented by the downward sloping diagonal axis. Modified perceptions, which arise after the assimilation-contrast effect has occurred, are represented by the upward sloping diagonal axis. Based on the work of Parasuraman, Berry and Zeithaml (1991), a zone of tolerance exists between adequate and desired levels of expectations or, put another way, minimal predictable expectations and achievable normative expectations, with normative expectations forming the upper bound of this range and minimum predictable expectations the lower. Predicted expectations fall somewhere in the middle of this band, and these are the expectations based on what is most probable or likely to happen. According to the model, the fulfilment of predicted or probable expectations will result in satisfaction, though probably not to a great level.

When initial perceptions are greater than predicted expectations within the zone of tolerance (represented by the solid grey area to the right of the dark curved line), the model posits a smaller amount of satisfaction than predicted by initial perceptions alone due to an assimilation effect. Conversely, when initial perceptions exceed predicted expectations outside the zone of tolerance, or in this case are greater than the expectable norm (represented by the chequered grey area to the left of the dark curved line), the model posits more satisfaction than predicted by initial perceptions alone due to a contrast effect. In the bottom half of the figure, the same principles apply in determining the likely amount of dissatisfaction. Therefore, outside the bounds of tolerance, there is an increasingly exaggerated tendency towards high satisfaction when initial treatment perceptions are well above achievable normative expectations. Similarly, there is likely
to be high dissatisfaction when initial perceptions of the treatment attribute are well below the minimum normative expectations.

![Diagram](image)

**Figure 3.2** Thompson and Sunol’s assimilation-contrast model of satisfaction.


Most typically in reviews of the satisfaction literature, a distinction is made between satisfaction judgments involving aspects of the delivery of care, such as the quality of client-staff interactions, versus the elements or outcomes of that care, such as whether certain procedures were delivered (Carr-Hill, 1992). Under assimilation-contrast models of expectancy disconfirmation, the nature of the curves are considered to vary according to these different dimensions of treatment. Parasuraman et al (1991) have argued that the zone of tolerance between adequate and desired expectations is narrower for the outcomes, or content, of treatment than for the way it is delivered. In this way, there is likely to be a smaller zone of tolerance for receiving treatment that
produces reliable outcomes than there is for receiving treatment in an appropriate manner.\footnote{Parasuraman et al (1991) use the word ‘outcome’ to refer to whether a treatment was done, not whether it resulted in a particular outcome. For the purpose of clarity, the term ‘content’ will be used in addition to, or in place of, ‘outcome’ in the remainder of the chapter. Similarly, the word ‘process’ refers to how a treatment is delivered, not what treatment was delivered.}

\textit{The Application of Assimilation-Contrast Models of Satisfaction}

To date, the operation of assimilation-contrast models such as those outlined in the previous section have not been directly tested in the health care arena. Most subsequent research attention has focused on defining and categorising the nature of expectations (e.g. Kravitz, 1996; Staniszewska & Ahmed, 1999). Like research into the nature of satisfaction, this work has been characterised by a diversity of approaches, with expectations about treatment experiences assessed both prospectively and retrospectively. The mostly widely agreed upon definition of expectations is that they are beliefs about the likely occurrence of some event or attribute that have either a negative or positive value (Linder-Pelz, 1982; Oliver, 1980). While there are many different labels used to classify expectations in the client satisfaction and consumer satisfaction literatures, the typology developed by Thompson and Sunol (1995) best describes the four most commonly cited categories. These are predicted, ideal, normative and unformed expectations. Research conceptualising expectations as predictions (e.g. Oliver, 1980) examines client beliefs about what is probable or likely to occur. These expectations develop from personal experience or knowledge of the experiences of others. Expectations conceptualised as ideal are those that tap client desires or wishes. They represent the client’s beliefs about the potential of a service. Research into normative expectations (e.g. Parasuraman, Zeithmal, & Berry, 1985) examines client perspectives of what should or ought to happen during an impending exchange rather than what is simply considered likely. They are related to a client’s sense of what is deserved and to some extent are socially endorsed. Normative
expectations form the upper and lower boundaries of the zone of tolerance in the Thompson and Sunol (1995) model. Finally, unformed expectations have been conceptualised as those instances where clients are unable to articulate what they expect because they may not have formulated any expectations. These include 'taken for granted' aspects of care and situations when clients have little prior experience of care on which to develop assumptions.

Little research has been undertaken into the factors which influence the development and modification of expectations. The process of assimilation described in the Thompson and Sunol (1995) model suggests that probable or predicted expectations about particular treatment attributes are likely to change as clients gain greater exposure to, and more experience with, those aspects of a service. As such, expectations are dynamic. Implicit support for this has been found in qualitative studies examining patient experiences of medical care (Staniszewska & Ahmed, 1999; Fitzpatrick & Hopkins, 1983) and mental health services (Williams et al., 1998). In these studies, patients revised their expectations about what was likely to happen upon being provided with information indicating what it was possible to expect.

With regard to factors influencing the development of expectations, Thompson and Sunol (1995) identify three types which they argue need to be taken into account. The first is personal factors, which includes the needs, values, roles and treatment intentions of the client. The second is social factors, such as the client's socio-demographic status and social norms. The third relate to the features of the treatment environment that make it unique. This suggests that the expectations clients develop about their treatment are likely to be specific to their individual circumstances and the nature of the program from which they access care.

Areas for Development

At this stage, many questions remain about the operation of assimilation-contrast models of satisfaction, particularly the one proposed by Thompson and Sunol (1995). Two aspects of the model are identified for refinement and examination.
First, Thompson and Sunol’s (1995) model implies that satisfaction and dissatisfaction are monotonically and orthogonally related to one another. As such, as outcomes increasingly exceed normative expectations, satisfaction becomes increasingly marked. Conversely, as outcomes fall increasingly below minimum predictions, dissatisfaction becomes significant. Further, where outcomes do not meet predicted expectations but fall within the minimally expectable range and are assimilated, the model suggests that dissatisfaction will result. Structuring the model in this way seems to be problematic on empirical and logical grounds, particularly when considering issues regarding the processes of treatment. As research investigating the nature of service encounters involving failure and recovery shows (Smith, Bolton & Wagner, 1999), client satisfaction with service is maximised when the requital for failures in service delivery is of a similar magnitude and type to the service initially expected. Put another way, clients are less likely to be satisfied, for example, when overwhelming contrition is offered instead of an expected simple apology for what would be commonly considered a minor mishap. Similarly, those who receive more goods than they believe they deserve are likely to feel embarrassed until they alter their norm of entitlement.

Conversely, it is difficult to conceive how dissatisfaction results from outcomes that were greater than the expectable minimum yet less than what was likely or predicted. There is some evidence to show how unmet predicted expectations are assimilated with treatment experiences to produce client evaluations of satisfaction. Williams and others (1998) explored the meaning behind high reported levels of satisfaction from clients of community mental health services who identified negative treatment experiences. It was found, firstly, that clients were unlikely to register dissatisfaction if they perceived that it was not the duty of the program to provide the service they had hoped for but failed to receive. In terms of the Thompson and Sunol (1995) model, then, while the program’s performance fell below predicted or probable expectations, this disappointment could be minimised and satisfaction registered by the clients because the program still performed within the bounds of what would be minimally acceptable for any organisation with a similar role. Secondly, clients were
found to not evaluate the program negatively even when they had experienced a negative outcome if there were sufficient mitigating circumstances for the poor result. As such, unmet expectations were assimilated to the outcome when the program was not perceived as culpable in the treatment failure. Therefore, unlike the Thompson and Sunol (1995) model, normative expectations around clients' rights and the organisation's responsibilities, represented by the minimum expectable prediction and the achievable norm, were the boundary markers within which clients evaluated negative experiences as being ultimately satisfactory.

Second, given that client expectations of care have been found to change over time (Fitzpatrick & Hopkins, 1983), particularly as client knowledge and experiences of care develop, the relationship of expectations to outcomes changes. As has been proposed, this relationship also varies according to whether the processes or contents of care are being evaluated. As stated earlier, therefore, satisfaction is a dynamic construct. Thompson and Sunol (1995) suggest that clients' personal needs and social needs as well as features of the program itself influence the creation of client expectations. However, there is no current formulation of which factors influence the development of which types of expectations, particularly the normative expectations that lie at the boundaries of the zone of tolerance where the contrast between what was expected and what is achieved starts to be exaggerated rather than minimised. Investigations of unmet client expectations in doctor-patient relationships that were not mediated through negotiations with the doctor suggests that younger clients and those who mistrust their physician are more likely to have unmet expectations and register dissatisfaction with the medical encounter (Bell, Kravitz, Thom, Krupat & Azari, 2002). These results are yet to be replicated.

A Reformulation of the Satisfaction Construct

In an attempt to address these issues, the Thompson and Sunol (1995) model was revised. The modified version is shown at Figure 3.3. The model suggests that a client will be satisfied when a treatment attribute or outcome falls within the range of tolerable normative expectations (represented by the solid grey area). Satisfaction is maximised
when outcomes most closely match predicted or probable expectations. In this way, satisfaction is increased with the increasing accuracy or *appropriateness* of the treatment response, not a response that exceeds the realm of the client’s expectations regarding what it is ‘normal’ to expect from treatment. Put another way, clients are likely to be most satisfied with treatment when they know what to expect from it and it is highly probable or likely that their expectations are realised. Treatment provision that clients rate as greater than what they considered probable yet within the bounds of what they expected to be achievable is likely to be pleasantly surprising to them and, once assimilated, should have the effect of raising the predicted expectations over time. (The reverse is also possible though perhaps not as likely. Clients who receive a greater level of service than what they predicted but a level of service which is within the bounds of what is considered achievable may be mildly annoyed because of overservicing.) Conversely, events that fall below what was anticipated yet are better than the expected minimum standard will lower expectations regarding likely care in the future. In short, treatment events that fall within the bounds of the zone of tolerance, once assimilated, are likely to be evaluated as satisfactory.

Figure 3.3. Proposed assimilation-contrast model of satisfaction.
The revised model also makes alternative assumptions to those of Parasuraman and others (1991) about the differences in the tolerance for unmet expectations clients have for the process and outcome dimensions of their treatment. As stated earlier, Parasuraman and colleagues (1991) suggest that clients will evaluate a service as satisfactory where its performance falls between the levels of achievable expectations and minimum predictable normative expectations and that the range of these expectations will be narrower for the outcomes or content of treatment than for the way it is delivered. This proposition was developed to explain consumer evaluations of customer service experiences, which differ somewhat in nature from the evaluations clients make in a health care context. Unlike consumption experiences in the retail sector, client experiences of health care usually involve several engagements with the service provider over an extended period. They also tend to involve the satiation of significant needs, not incidental wants or desires. As such, they encompass a broad range of emotional responses that can more significantly impact on the relationship between the client and the service provider. For these reasons, it is argued that in the health care arena no fixed assumptions about differences in expectations for the outcome or process of treatment can be assumed. The zone of tolerance for unmet expectations regarding the processes of care is just as likely to be of a similar range, if not narrower, than that related to the outcomes or content of care.

This said, it is possible to make some predictions about the amount of tolerance clients will have for unmet expectations regarding both the processes and outcomes, or content, of care. Thompson and Sunol (1995) proposed that a relationship exists between the client’s personal and social profile and the nature of his or her expectations for treatment. In light of this, it is argued that the size of the zone of tolerance for unmet expectations is likely to be based on the extent of the personal and social needs of the client. As such, it could be reasonably expected that health care clients with greater needs for emotional support and assurance, for example, will have a much smaller range of tolerance for unmet expectations involving the manner in which treatment is delivered by their service provider than those exhibiting better psychological and social adjustment to their problems. Similarly, clients who have complex health problems that
require chronic levels of care may have a broad tolerance for outcomes that vary from what they predicted.

It is proposed that the range of tolerance for the processes and outcomes of treatment can be assessed by examining the nature of the client’s reaction to unmet expectations. Like the Thompson and Sunol (1995) model, the revised model assumes that treatment experiences will be assimilated with unmet predicted expectations but contrasted against unmet normative expectations. In the revised model, the process of assimilation results in an expression of satisfaction while the process of exaggeration or contrast results in dissatisfaction. It is suggested that assimilation most probably involves attitudinal changes on the part of the client while expressions of dissatisfaction increase the likelihood of a negative behavioural response, such as a complaint, a withdrawal of involvement in the treatment or some act that averts the impact of the unsatisfactory experience. In short, clients will respond to breaches of predicted or probable expectations with an attitudinal shift of some kind and to breaches of normative expectations with some behaviour.

In summary, the proposed model suggests that satisfaction judgments are relative to clients’ expectations of treatment. These expectations exert a non-linear influence on client evaluations, resulting in satisfaction when there are minor discrepancies with treatment experiences and dissatisfaction only when there are significant differences. This accounts for the generally high reported levels of client satisfaction in the literature. Clients will remain satisfied when their expectations regarding probable treatment scenarios are unmet, but they will be dissatisfied if treatment does not meet their normative standards. This variation in the effect of the different types of unmet expectations is therefore an indicator of the degree of seriousness or importance of the issue to clients. Moreover, their tolerance for normative breaches regarding some aspect of treatment is likely to be lower if they have a particular personal need in that area. When their norms for treatment are not fulfilled, clients are likely to express their dissatisfaction behaviourally.
This specification of the constituent elements of client satisfaction and how they work is incomplete without a discussion of the domains of treatment to which they apply. The work of Parasuraman and colleagues (1991) goes some way to serving this end. As has been established, satisfaction judgments are based on either aspects of the delivery of care, such as the quality of client and staff interactions, or the contents or outcomes of that care, such as whether certain procedures are delivered. However, this broad distinction is not enough to obtain an understanding of what clients may be satisfied or dissatisfied with. Program directors need to know, for instance, which specific parts of a program are unhelpful for clients and how in order to develop ideas about how to improve them. The following section will address this issue by detailing a system for classifying the context in which satisfaction judgments are made.

**Classifying the Domains of Assessment: Client Satisfaction as a Function of Interpersonal Exchange**

As noted at the beginning of this chapter, satisfaction is not a unidimensional construct. The potential instances of dissatisfaction and satisfaction could be many and diverse so it may not be appropriate to combine ratings of satisfaction with various domains of treatment into one index of satisfaction as many quantitative instruments do (Carr-Hill, 1992). If this approach were employed, dissatisfaction with one aspect of care could potentially be cancelled out by rated satisfaction with others. As such, it is necessary to consider clients’ evaluations of a range of treatment domains individually. This requires a coherent classification system.

The components of care on which measures of satisfaction are based can be classified in a variety of ways, especially when the specific context in which treatment is delivered is taken into account. In primary health care, a popular standardised taxonomy has been developed out of an analysis of the most frequently evaluated components of medical services (Ware, Synder, Wright & Davies, 1983). Using this framework, satisfaction judgments are assessed according to eight dimensions of treatment—namely, the interpersonal manner of its delivery; its technical quality; its accessibility; its cost and other financial aspects; its efficacy; the constancy of care; the physical environment in which it is delivered; and its availability. A subsequent
assessment of the relative importance of these various treatment domains in satisfaction judgments indicated that, apart from the professional competence of providers, the quality of the client-service provider relationship was the most important criterion in ensuring the satisfaction of clients (Williams & Calnan, 1991). While it has been noted that the construction of such categories is biased to reflect the concerns of providers rather than clients (Sitzia & Wood, 1997), the nature of engagement between service providers and clients is the one component of treatment that could be argued to underpin most of the remainder. Therefore, the appropriate framework for assessing clients’ satisfaction with various domains of treatment was considered to be relationally based.

Satisfaction From a Social Exchange Perspective

Social exchange theories are based on the notion that social life can be construed as a series of transactions between individuals whose exchanges of personal resources provide each of them with a range of rewards and costs. Most theories (eg. Blau, 1964; Homans, 1961; Thibaut & Kelley, 1959) have been concerned with identifying the rules or norms upon which individuals learn to maximise their gains and minimise their losses in relation to one another. Such an approach is sympathetic to current approaches of client satisfaction in three respects. First, as indicated above, the relationship clients have with service providers has been found to form the foundation of their evaluations of treatment. For example, the interpersonal quality of care offered by providers, shown in their communication of understanding, interest and reassurance to clients, has been found to be one of the principal components of client satisfaction (Sitzia & Wood, 1997). Second, most satisfaction research, by seeking to identify the factors that maximise the fulfilment of the client’s expectations of treatment, could be argued to be concerned with understanding the principles of reward maximisation. Finally, like the social exchange theories referred to above, contemporary models of client satisfaction are interested in understanding how normative expectations of behaviour influence people’s interpretation of, and response to, events. This is based on the idea that expectations about what individuals believe they deserve or are entitled to are acquired over their history of interpersonal exchanges. As such, clients’ predictions about likely
outcomes in treatment are unlikely to extend beyond the rules of normative social exchange.

The Utility of Resource Theory in Assessing Social Exchanges

By specifying the rules governing interpersonal transactions, most social exchange theories have paid little attention to what is exchanged and how that may impact on the patterning of the interaction. Like the economic theory from which they were derived, social exchange theories, particularly in social psychology, have traditionally focused on the exchange of economic or tangible resources in relationships, such as money or goods (Thibaut & Kelley, 1959). However, intangible or interpersonal resources, such as gratitude, respect and friendship, are also transacted along with items such as money and merchandise. These forms of non-economic exchange have been largely ignored in traditional studies of social exchange. The effects of the setting or context in which items are transacted, the needs or motivations of the participants involved in the exchange and the history of their relationship have also been neglected.

Resource exchange theory aims to address these issues by considering the transmission of not only tangible material goods and services but also abstract symbolic resources, such as feelings of positive regard and information (Foa & Foa, 1974; 1980). Its importance lies in its ability to explain how individuals satisfy both their physical and psychological needs by developing rules for trading different classes of interpersonal resources based on these abstract and concrete forms. It can also account for the fact that exchange is affected by not just the resources involved but also the social and institutional context in which the exchange occurs, the nature of the relationships between the participants and the needs of each party.

Resource exchange principles were considered particularly appropriate for use with the proposed model of client satisfaction because they are capable of accounting for the process aspects of treatment, which involve the transmission of symbolic resources such as trust and respect in the relationship between the client and service provider, as well as the content of the treatment itself, which involves the transmission
of concrete, fungible resources. The principles of the theory most relevant to this issue are considered in the following section.

*Applying Resource Theory in Classifying the Domains of Assessment*

Resource exchange theory offers a classificatory framework for interpreting social interactions. It characterises those interactions according to the patterns or rules of exchange for six universal resource categories. These are *love*, being expressions of affectionate regard, warmth or comfort; *status*, being expressions of judgments that convey high or low prestige, regard or esteem; *information*, being advice, opinions, instruction or enlightenment; *money*, being any coin or currency used as a standard unit of exchange; *goods*, being tangible products, objects or materials; and *services*, being activities regarding the body or belongings of a person that constitute labour for another person (Foa & Foa, 1974:37). The pattern of exchange for these resources is determined according to the ordering of the resources along two dimensions, as shown in Figure 3.4.

![Figure 3.4 Circumplex of the six resource classes.](image)

The first dimension, concreteness-symbolism, specifies the kind of behaviour associated with the resource. Exchanges of goods and services are the most concrete as they involve tangible products or activities. Conversely, exchanges of status and information involve mostly symbolic acts. Money and love both involve symbolic and concrete expressions; money can be exchanged electronically or with currency, and love can be expressed symbolically through words or concretely in behaviour. The second dimension, particularism-universalism, refers to the degree to which the value of a resource is affected by the particular individuals who exchange it and the nature of their relationship. Money, for example, retains the same value regardless of who exchanges it. However, it matters very much with whom love is shared, and love has different forms of intensity in different kinds of relationships. Services and status are less particularistic than love but more so than goods and information. Items in neighbouring resource classes are likely to be more similar than those from distal classes. As such, while the structure of the resource classes is constant, the boundaries between adjoining classes is permeable. (For a review of evidence supporting the ordering of the resources along these dimensions, see Foa, Converse, Tornblom & Foa, 1993.)

The above categorical representation of the contents of interpersonal exchanges offers a simple system for defining the process and content dimensions of treatment. As stated earlier, the process of treatment relates to the manner in which treatment is delivered. This implicates factors associated with the quality of the relationship between the service provider and the client. As such, it concerns the exchange of the more particularistic resources, such as love, status and services. The content of care includes all the constituent elements of treatment whose value is not dependent on the nature of the association between the parties in the treatment relationship. It is represented by exchanges of universalistic resources such as goods, money and information.

2 In the context of a treatment program, however, love is assumed to be expressed mainly in symbolic terms and money is considered to be exchanged as concrete currency.
While any treatment episode involves both the process and content dimensions of care and, therefore, involves the transmission of both particularistic and universalistic resources, clients tend to evaluate situations by stressing the predominance of one resource type over another. For example, a client may report that his doctor insulted him while taking his blood pressure by implying that people receiving welfare payments, such as the client, are lazy. In resource terms, this exchange involved the provision of a service as well as the removal of status. However, if the client’s evaluation of the incident stressed the importance of receiving the insult over the blood pressure test, it could be classified as an expression of dissatisfaction with an aspect of the process of treatment—namely, an issue of client status.

Importantly, events are represented by a resource category according to the meaning to the client of the set of behaviours involved, not the behaviours per se. The same behaviours can vary in meaning across different contexts, so the meaning of a particular event is an act of individual evaluation. Using the above example, the same event would not be rated as indicating dissatisfaction with a status issue if the client perceived that the comment from his doctor was part of a joke they shared about the stereotypes of welfare recipients. In this instance, it could represent an example of the client’s satisfaction with the treatment relationship inasmuch as his interaction with the doctor involves a degree of shared understanding and affection (Turner, Foa & Foa, 1971). The event would then be classified as an exchange involving the resource category of love. This approach to classifying client evaluations of treatment satisfaction thus requires client-centred, qualitative data gathering methods.

Classifying the dimensions of treatment according to the exchange of these six resource types suggests that the processes and content of care have several distinct qualities. First, a variety of evidence utilising resource exchange theory suggests that universalistic and particularistic resources are not generally substitutable for one another if an interpersonal exchange is to be considered satisfactory by the participants (Foa & Foa, 1974). In evaluating treatment, therefore, clients will not regard the content and process dimensions of care as interchangeable. They are not likely to regard the receipt of technically competent service as a form of compensation for lapses in the
standard of its delivery. For example, clients who expect a service provider to be friendly, a form of the resource of love, and instead encounter rudeness from that individual are unlikely to feel satisfied with that aspect of their treatment even if the goods they receive exceed their predicted expectations. Clients are likely to evaluate the two aspects of care separately. This is consistent with the finding in the client satisfaction literature discussed earlier that the interpersonal aspects of treatment form a component of client evaluations that is clearly distinct from those involving the content of treatment (Sitzia & Wood, 1997).

Second, differences in the nature of particularistic and universalistic resources and the rules by which they are exchanged are likely to result in differences in the standards by which the processes and content of service are evaluated. The process aspects of treatment are likely to be evaluated on the basis of several interactions between the service provider and client while conclusions about the content of treatment may relate to only single episodes of care. This is because, unlike universalistic resources, the satisfactory transmission of particularistic resources such as love, status and services is dependent on the successful establishment of a relationship, which takes time (Foa & Foa, 1974). The products of singular exchanges of particularistic resources cannot be retained for long without further exchanges because their receipt is integral to the actual interpersonal interaction. Alternatively, resources such as goods and money can be satisfactorily received in a single transaction and preserved individually over time. Moreover, exchanges involving particularistic resources can involve more ambivalence than those involving universalistic resources, which makes evaluations about them complex. For example, it is possible to receive a compliment delivered in a sarcastic tone, whereby status is endowed yet at the same time is denied. On the other hand, goods or money cannot be both given and taken away in the same transaction (Foa & Foa, 1974). Given the highly contingent nature of particularistic resource exchange, therefore, it is assumed that clients will use different criteria when assessing the processes versus the contents of care.

Third, as has been proposed, individual differences in clients’ personal and social needs influence their amount of tolerance for unmet expectations regarding the
process and content dimensions of treatment. The principles of resource exchange theory would suggest that, aside from these individual differences in need, tolerance for variations in the way treatment is delivered is likely to be smaller than for variations in the content of the treatment itself. This is based on the notion that for each class of resource, there is an optimal range of each resource type possessed by individuals (Foa & Foa, 1974). When individuals have resources within this range, they are not motivated to want to acquire them. When the amount of a possessed resource falls below the optimum range, the individual will be likely to experience a need for the resource and be motivated to ensure its acquisition. As such, clients should place a greater premium on achieving the fulfilment of expectations involving the needed resource type. However, because the exchange of particularistic resources is more contingent on environmental factors, such as the nature of the exchange relationship and the frequency of interactions, the optimal range for the personal possession of particularistic resources is generally narrower than the range for universalistic resources. Support for this argument has been obtained in studies of the divorce adjustment of non-custodial fathers (Rettig, Leichtentritt & Stanton, 1999) and family life quality (Rettig, Danes & Bauer, 1993).

In summary, this framework for classifying client evaluations of treatment satisfaction is based on broad yet psychologically coherent categories that can be applied to most components of a treatment program. It provides a map for organising the aspects of treatment clients report as significant without defining or presupposing the importance of specific features of the treatment experience. As has been shown, the clusters of particularistic and universalistic resources can account for the process and content aspects of treatment respectively. Given that the patterns of exchange for these different resource types are quite different, it is likely that clients will make separate assessments of the process and content areas of treatment, use different criteria when evaluating them and have different levels of tolerance for unmet expectations regarding each of them.
Conclusion

This chapter has reviewed the current literature on client satisfaction with opioid replacement therapy and found that the usefulness of the findings has been bounded by the methods used to assess it and the definitions afforded the concept. Satisfaction is not an absolute, unitary construct that can be assessed out of the context in which it applies. Models that acknowledge this relativity assert that satisfaction is the by-product of the discrepancy between what happens to clients and what they expect would happen. In this chapter, a current version of one of these models was reformulated for use in assessing client satisfaction in a health care environment treating clients with complex and chronic needs. A framework for classifying the elements of treatment identified as significant by clients was also developed. This is based on the assumption that all components of treatment, in their elemental form, involve acts indicative of personal interdependence between the client and service provider. A theory categorising the type of resources exchanged in the treatment context was employed because of its ability to account for the particular and universal aspects of the interpersonal encounter between client and provider.

In summary, this model will provide the means by which client satisfaction with the opioid replacement treatment as it is currently constituted and was described in the preceding chapter can be examined. Its successful application to the issues identified in that chapter is dependent on the use of an appropriate methodology, the details of which are described in the following pages.
Chapter 4 – Methodology

Introduction

This chapter presents the rationale for, and outline of, the methodology used in the empirical studies reported in the following chapters. This is presented in two parts. The first is a description of the research agenda upon which the methodology is based. The second is a discussion of decisions regarding methods of sampling, data collection and data analysis pertaining to specific studies and the ethical issues bearing upon their implementation. In considering the second part of the chapter, it is important to note that the focus is the rationale for the use of particular methods. The particular methods employed are detailed in the method section of each of the reported studies.

The Research Plan

The empirical research presented in the following four chapters has two general aims. The first is to evaluate client satisfaction with opioid replacement therapy in light of the core issues affecting the current Australian treatment environment highlighted in Chapter 2. The second is to explore the operation of the model of client satisfaction outlined in Chapter 3 to assess its suitability for application in other health care contexts.

Aims and Objectives

The above propositions translate into the following more specific aims and objectives:

- To describe the treatment profile and policy settings of an opioid replacement therapy program utilising both clinic and community based service providers

Given the increasing involvement of small-scale private sector treatment providers in the delivery of opioid replacement therapy and the challenges this creates in coordinating clinical responsibilities with the public sector, the thesis aims to describe the profile of a program incorporating both clinic and community treatment formats. In particular, it aims to describe the program’s structure and rules; the characteristics of the treatment staff; the dosing arrangements; the ancillary services provided; and its
treatment policy. The treatment orientation of the principal service providers will be assessed to identify provider attitudes towards harm minimisation principles and abstinence based treatment policies. Provider attitudes and approaches to the management of relationships with clients will also be obtained. In total, this information will serve to identify institutional constraints on the expectations clients develop about their treatment program.

- To describe the profiles of clients receiving clinic and community based opioid replacement therapy

As reported in Chapter 2, current Australian government policy envisages a changed role for public clinics providing opioid replacement therapy whereby public clinics will assess new treatment applicants, retain clients with more complex needs and transfer more stable clients to community providers. At a clinical level, stable clients are defined in functional terms through their regular and reliable contact with service providers, absence of intoxication when dosing, absence of antisocial or violent behaviour and adherence to treatment program conditions (New South Wales Health Department, 1999). However, it is not clear to what extent there are significant differences in the psychosocial profiles of clients managed in public clinics and clients based in the community sector.

The thesis aims to describe the personal resources which clients bring into the treatment environment and to see whether these vary for clients in clinic and community based treatment. This will provide material to highlight prospective personal needs that shape client expectations about, and reactions to, the treatment environment. Client resources will be profiled by collecting data on their demographic characteristics, treatment history, drug use history and current social, physical and psychological functioning. It is uncertain whether there are significant differences between clinic and community clients on measures such as these. The transfer of stable clients from clinic environments to the community suggests that there will be some differences in the levels of personal functioning between the two groups. As such, it is anticipated that
Clinic clients will have potentially a greater need for a range of personal resources and, therefore, have a narrower zone of tolerance for having their expectations fulfilled.

- To specify the aspects of treatment evaluated by clients as satisfying and those evaluated as unsatisfying; to describe the determinants of these evaluations and their impact; and to examine the processes clients use in making decisions about their engagement in treatment based on these evaluations.

The research reviewed in Chapter 2 suggests that a number of aspects of opioid replacement treatment as it is currently structured would be possible sources of significant interest to clients. These include the everyday management of relationships with service providers, particularly in the community sector; the imposition of treatment fees; the negotiation of dose levels; the structure of dosing arrangements; and access to, and the negotiation of, counselling and medical services.

The thesis aims to describe both positive and negative treatment events clients identify as being significant experiences in their care. In particular, events will be categorised according to a resource type to enable both the process and content dimensions of the treatment environment to be mapped.

The thesis also aims to explore the processes by which clients resolve any discrepancies between their expectations and experiences. The model would suggest that differences between predicted or probable expectations and outcomes will be assimilated by clients, producing a report of satisfaction with the nominated event. On the other hand, clients will tend to exaggerate any discrepancies between their normative expectations and treatment experiences, which means these events will likely be evaluated as unsatisfactory experiences. In the case of satisfactory interactions, the predicted expectations will be identified. For negative experiences, the thesis aims to describe the normative expectations influencing what clients believe they were entitled to receive in the circumstances and how they should have received it.

The thesis also aims to identify the outcome of unmet expectations on clients' response to the treatment encounter both for themselves and their involvement with the
service providers and the program generally. This will involve an examination of the attitudinal and behavioural effects of breached expectations for the client. Finally, any commonalities in outcomes for similar treatment events will be assessed against the client profiles to identify whether particular subgroups of clients, such as more stable or unstable clients, or those with a particular set of personal resources are more likely to encounter particular kinds of experiences in their treatment.

Plan of Empirical Research

Chapters 5 to 8 report on three studies which have been carried out to assess the above aims. The Southern Area Health Service (SAHS) opioid agonist treatment program was approached to participate in the research for two reasons. Firstly, and most importantly, the program operates with a combined public sector clinic and private sector community based format. As its clients are likely to have experience of both arms of the program at some point in their treatment, they would be in a favourable position to undertake an evaluation of the relative benefits and disadvantages of these forms of treatment. Secondly, covering a large area of southern New South Wales, the SAHS was considered an important source of information on clients in rural and regional treatment programs in Australia, about whom little is currently known.

Chapter 5 reports on a set of individual interviews conducted with case managers, general practitioners and pharmacists working for the SAHS as well as a documentary analysis of the policies of the same program. This study describes the treatment and policy settings of the SAHS in order to describe the context within which clients receive care. In particular, it sought to clarify the treatment orientation and therapeutic approach of those staff working with the largest proportion of the client sample used in the subsequent studies.

Chapter 6 reports on a pilot study designed to test the viability of categorising treatment events using resource exchange theory principles and to identify probes for the client interviews in the third study. This study describes a series of focus groups conducted with a sample of clinic and community based clients at one study site to identify their perspectives on the most important issues in their current treatment
environment. The results are considered in light of the capacity of the six resource types to account for the issues identified by clients.

Chapter 7 reports on the collection of a set of quantitative data pertaining to the profiles of the clients interviewed in the third study. This study addresses the issue of whether there are significant differences between clinic and community based clients in terms of their demographic features, history of opioid replacement therapy, current and past drug use and social, health and psychological functioning. Finally, Chapter 8 reports on individual interviews conducted with the same client sample regarding significant treatment experiences for them in the current program. This study seeks to identify the aspects of treatment in the SAHS program that clients find satisfying as well as those regarded as unsatisfactory, to identify the sources of those evaluations and to establish their impact on both the clients and the program. This study also examines the processes clients engage in to arrive at decisions about their involvement in treatment.

Rationale for the Method

Research into alcohol and other drug problems is undertaken by individuals working across the spectrum of social science disciplines from anthropology and sociology through to psychology and epidemiology. The choice of working methods of researchers in each of these disciplines has been traditionally governed by a preference for either qualitative or quantitative methods of data collection and analysis. However, much contemporary empirical social research, particularly fieldwork, involves the use of both (Silverman, 1995). Some social science commentators (e.g. Bohman, 1991) argue the importance of researchers making explicit the principles upon which they employ various data gathering techniques and the criteria they use for favouring one theoretical explanation over another. This is particularly true for qualitative research, which has many different forms and traditions. In respect of this argument, it is firstly noted that the exploratory nature of the project suggested a predominantly qualitative methodology be employed (Silverman, 1995). Secondly, given that client expectations regarding treatment are assumed to be shaped by aspects of both the profile of the
individual clients as well as the profile of the program, the form of the methodology was influenced by critical realism (e.g. Bhaskar, 1997; Outhwaite, 1987). In short, a critical realist methodology provides a way of examining the intentions and meanings held by individuals operating within the framework of rules and conventions that comprise social institutions. Since greater familiarity with its principles is unnecessary to an understanding of the particular methods and data presented in the remainder of this thesis, however, they are not considered further here. (See Sayer, 1992 for an introduction to critical realist methodology.)

The remainder of this chapter takes as its focus the methodological decisions made in each of the three major stages of the project: the literature review, where the key concepts for investigation were abstracted from the research into opioid replacement treatment; the empirical studies, where the conditions of treatment under which these concepts are likely to apply were examined; and the presentation of the conclusion, which situates the research findings within the broader research literature. For the sake of clarity, the order of the stages of the research reported herein corresponds with that of the chapters presented in the thesis. The chapter concludes with a discussion of the ethical implications of these methodological choices.

The Abstraction of Key Concepts from the Empirical Evidence

The review of the empirical and theoretical literature outlined in chapters 2 and 3 respectively provided the starting point for reconceptualising the key elements of client satisfaction and the possible means by which they manifest in clients’ engagement in community and clinic based opioid replacement treatment. The review of the literature reported here enabled the key factors and concepts of analysis to be identified at a broad level and their likely relationship to be enunciated. The exploratory conceptual framework that resulted from this process subsequently bounded the development of the research questions and the choice of working methods (Miles & Huberman, 1994). It is shown in Figure 4.1.
The one-way arrows in this framework reveal general predictions about how the key psychological variable of interest in generating client satisfaction judgments—that is, expectations—is shaped by both program and client factors and how expectancy disconfirmation through significant treatment events influences client involvement in treatment. The postulation of expectations as a key causal factor in satisfaction judgments was determined from a review of the research literature on client satisfaction.

Unlike past theoretical and empirical work, which conceives of satisfaction judgements as a largely psychological process to the neglect of contextual influences and outcomes, this formulation accounts for their effect in a dynamic, systemic sense. In short, it shows the broader social structures as well as the intrapersonal factors that bound the development of clients' expectations. For example, clients may not act on their unmet expectations if the program at a structural level has few alternative means by which they can achieve their goals or the clients have personal circumstances which
impede their innate capacity to get what they want. Conversely, clients may negate their personal expectations in order to meet the program's expectations of them as clients. This conceptualisation is exploratory as it makes no specific claims about the internal dimensions and structure of client expectations, the mechanisms by which expectancy disconfirmation occurs or the power of expectations to affect client attitudes and behaviour in the program.

*The Assessment of the Conditions of Treatment*

The three empirical studies reported in chapters 5 to 8 assess the usefulness of the above framework by taking as their starting point the issues and events both clients and service providers report as significant in the treatment program. In order to enable clients' subjective reports to be analysed intensively and yet remain situated within the broader objective domains of the treatment regime, variation in both information sources and type of data captured, often referred to as triangulation, was used (Silverman, 1995). As stated earlier, Chapter 5 reports the findings of documentary analysis and in-depth interviews with service providers to highlight the parameters of program delivery and service provider engagement with treatment. The pilot study reported in Chapter 6, which had a more theoretical purpose, utilised focus groups of clients to examine the feasibility of using concepts derived from resource exchange theory to analyse events in opioid replacement therapy. Finally, chapters 7 and 8 report a study of client experiences where in-depth interviews with individual clients were used to elicit significant treatment events and standard questionnaires were able to extract a profile of client needs. Overall, discrepancies in the data produced from these various sources, implying a gap between people's perception of the program and its actual structure—or a distinction between its appearance and essence—was the starting point for identifying the structure and operational mechanisms of client expectations. The final analytical propositions regarding expectations were derived after their applicability to the entire data set could be reliably established and their innate validity could be verified. The rationale for each specific methodological decision related to this stage of the project is considered below.
Sampling In both studies where clients participated—that is, the focus groups reported in Chapter 5 and the individual interviews and questionnaires analysed in chapters 7 and 8—maximum variation in respondent profiles across all the major dosing sites in the SAHS was sought. Overall, this process enabled the theoretical concepts to be assessed against the greatest possible range of treatment conditions.

In order to maximise the likelihood of gaining a diverse sample, the recruitment procedure for the client studies involved a variety of methods. Letters and pamphlets containing the details of the groups or interviews were distributed to clients either directly or through service providers. Both clinic and community clients were also approached directly. The final method of recruitment within sites was snowballing, whereby former participants referred peers who were also members of the program. This latter sampling method could be argued to invite interview participants with consensual rather than discrepant opinions inasmuch as participants are likely to nominate people with whom they maintain contact and, to some degree at least, have either shared experiences or who share their perspectives. This said, less than 10 per cent of the sample—that is, six clients—would have been obtained through the use of this strategy. The service providers were recruited through direct approach once all the client interviews were completed.

Data collection Instrument selection in the empirical research was determined by the type of information required to understand the operation of each component of the conceptual framework (see Figure 4.1). Given that the investigation of program factors such as the service providers' treatment philosophy and the policy and treatment guidelines of the SAHS was generally exploratory in that it was unclear what elements of their activities would influence client expectations, semi-structured qualitative methods of data collection were employed. In the case of the treatment providers, an interview schedule with only broad themes of theoretical interest was used so that reasonable comparisons of responses could be made across individuals yet the respondents retained the opportunity to highlight areas of most significance to them. The analysis of policy and treatment guidelines involved summarising the central planks
on which service delivery occurs so that it could form a benchmark against which client experiences could be compared.

The assessment of client factors such as the respondents' demographic profile, current and past drug use, drug treatment history and their social, psychological and physical health was undertaken with highly structured questionnaires incorporating some well-validated and reliable instruments used in prior research with illicit drug users (e.g. the Millon Clinical Multiaxial Inventory). This was done not only to acquire uniform and comparable data across the client sample but also to maximise the efficiency of data collection where access to individual clients was restricted to a single encounter and semi-structured interviews about treatment experiences demanded most of the scheduled time.

Probes for the individual interviews of client experiences were developed out of the themes raised in the focus groups. However, these were only used as prompts when clients expressed difficulty identifying any significant events or experiences in their treatment. In order to maximise the collection of context-rich information and enable strategic comparisons with other components of the conceptual framework, the individual client interviews were designed to be 'open', or free-ranging, in style, whereby the subject matter was determined by the participant as long as it pertained to program experiences. In all interviews with both clients and service providers, the aim was to gather the data as unobtrusively as possible so that participants felt more relaxed about elaborating on their experiences.

**Data analysis** In general, the analysis of the data proceeded from a focus on the information obtained about each component of the conceptual framework to a more holistic examination of the relationships among them. This enabled the necessary relations among the themes to be abstracted and the structures and mechanisms of client expectations to be hypothesised and then re-tested against the data sample.

The quantitative data from the questionnaires administered for the purpose of profiling client needs was analysed with both descriptive and inferential statistical tests.
This allowed the emergence of any reliable patterns of difference between community and clinic based clients that might inform subsequent analyses of their treatment experiences as reported in interview. In itself, this process was neither purely theory building nor theory testing. The quantitative data merely served to reveal whether any variation in the events identified by clients were contingent on their dosing within a clinic or a community environment. Given that there were no normal distributions in any variables, non-parametric statistics were used to analyse the data. The probability value for a type I error was set at 0.05. This said, because the research was exploratory, differences approaching significance were also discussed.

The remaining data, which were qualitative in nature—namely, the transcripts of interview with clients in both the pilot study and the main evaluation as well as the service providers—was initially analysed through the application of broad overlapping descriptive coding categories informed by the theoretical research. These broad, conceptually derived codes served an indexing function in organising the perspectives of the respondents. More refined subsets of these codes were also developed whereby items within the same code were compared and clustered by type so that both maximum distinctiveness between them and minimum variation among them could be achieved. The use of overlapping codes was considered useful inasmuch as it served to reduce the risk of fragmenting, decontextualising and, therefore, producing distorted interpretations of the data. As such, the themes developed from this stage of the analysis could most closely resemble a map of the complex empirical, or actual, reality of each reported treatment experience. This content analytic style of analysis was sufficient for extracting the final results from both the client focus group data and the service provider data. However, it formed only the first level of analysis in the main study of client satisfaction reported in Chapter 8.

The second level of qualitative analysis related to the development of the final explanatory model of client satisfaction. Once all the data pertaining to each component of the conceptual framework had been analysed—that is, the assessment of client needs, program factors, client expectations, significant treatment events and client outcomes had been completed—an holistic assessment of the relationships among them could be
undertaken for each client. This enabled the specification of the contingent circumstances under which unmet client expectations would be acted upon. In particular, it aimed to identify which, if any, elements of the program and/or the client's personal profile influenced the generation of client expectations; what kind of event outcomes, if any, were associated with unmet expectations and how this occurred; and what influence different kinds of outcomes had on aspects of the program and/or the client and how this was transmitted. Common themes and trends in the relationships among different variables in the framework across groups of clients were then identified and explanations were postulated that could account for any deviant or contradictory examples among them. Frequency counts of themes in each relationship were used as an adjunct to this stage of the analysis to provide a check on bias, where there was a tendency for the researcher to want to 'see' confirming instances of evolving theoretical ideas (Rhoads, 1991; Silverman, 1995).

The final stage of the analysis involved postulating a set of if-then hypothetical statements to test the propositions derived about the structure and operation of client expectations and their power to influence client attitudes and behaviour in treatment given the presentation of certain types of treatment events. These hypotheses were tested by applying them to randomly selected client case data and assessing their ability to account for the reported events. Explanations were considered adequate when under particular circumstances they could be shown to reliably produce a specified outcome across different cases.

The Development of the Final Explanatory Model

The second half of Chapter 8 outlines the final model used to explain the structure and mechanisms generating expectations in client satisfaction judgements in opioid replacement therapy. This model defines the set of necessary abstract elements comprising client expectations and describes how and to what degree they can affect client attitudes and behaviour when certain treatment events arise. It is then evaluated in Chapter 9. The soundness of the conclusions underpinning the model was verified by the following reliability and validity checks.
Reliability  Apart from the reliability checks for sampling mentioned earlier, guards needed to be made against potential biases in the collection of interview data, particularly from the clients but also from the service providers. Firstly, it was possible that the respondents’ report of events was coloured by their discovery of new connections while relaying their story and the researcher further shaped their meaning by summarising and reflecting back those comments to them during the interview. Secondly, and particularly with the clients, there was the possibility that only commonly understood ‘party line’ views of treatment would be presented. Of these two issues, the second was considered the more serious. With regard to the first, it was considered that without processes of reflection, which communicate to the respondent that he or she is being listened to and understood correctly, some client reports would have been considerably less elaborated and, therefore, rich in detail. Bias resulting from the second threat was minimised by the researcher’s noting common respondent accounts, especially those incorporating common evaluative slang, reflecting this fact back to the respondent and noting his or her reaction. Moreover, only first-hand, not hearsay, accounts of treatment experiences were coded.

Reliability in the analysis of client reports of significant treatment events was maximised through coding checks which specified at least a 90 per cent level of agreement between the coders. Bias in explanations drawn in the later stage of analysis was reduced by testing them against accounts provided by clients who stood to gain or lose the most from providing a view contrary to common opinion.

Validity  The validity of the findings was strengthened in several ways. First, clear definitions of concepts derived from theoretical sources were provided and applied consistently throughout the project. Second, detailed descriptions of the data obtained always preceded its interpretation and the configuration of context dependent factors was made clear. Interpretations of qualitative material also included detailed quotes from source data to reveal the basis upon which they were made. Third, where possible, feedback was obtained from respondents regarding the accuracy of the proposed results, and the means by which this occurred were clearly outlined. Finally,
the conclusions about the model of client satisfaction derived from the project included an assessment of its applicability to other chronic health care settings.

**Ethical Considerations**

Approval to conduct the research was sought and granted by the human research ethics committees of the Australian National University (ANU) and the South Western Sydney Area Health Service, the organisation which oversees the evaluation of research ethics of the SAHS. The issues of concern to these bodies were informed consent, confidentiality and the avoidance of harm, including through systems of reciprocity.

**Consent**

Informed consent was obtained from respondents through the use of a form, the contents of which had been approved by the ethics committees. At interview, the researcher summarised the main points of the form with respondents to ensure they knew what they were signing.

**Confidentiality**

Confidentiality was managed by storing the physical data in separate locked filing cabinets at the ANU and any electronic files in password protected computers. All respondent contact information was destroyed upon the completion of the project.

Given that the project involved the study of individuals living and working in a number of small communities, there were risks regarding the preservation of individual anonymity. Despite reporting findings in a de-identified manner, it was highly likely that local identities could still be identified from the description of local settings in which they operated. This was particularly the case where in one region there were only two service providers with quite different methods of operation and almost all the clients in the local area had problems with only one of them because of the same issue. In this instance, conflicting accounts of the few clients who reported no problems in this regard were scrutinised in order to assess the solidity of the conclusions and then any particulars deemed irrelevant to the interpretation were removed from the description of the setting.
Where possible, the privacy of respondents was preserved by interviewing them alone. This was possible in a clinic environment where a special room was available for this purpose away from the dosing site where clients interacted. For community based clients in rural and coastal areas, privacy was maintained by interviewing them in their home. However, this practical arrangement meant that couples on the program usually wished to be interviewed together, particularly when there were time constraints because of travel distances that would have made consecutive interviews unseemly. Moreover, for safety reasons, the researcher was accompanied by an assistant on these occasions. As such, it is possible that the quality of the information gathered from respondents in these circumstances was reduced. However, before an interview was conducted in these circumstances, all respondents were offered the opportunity to speak alone with the researcher if that was their preference. Only one couple expressed a desire to engage in consecutive interviews and this was for the purposes of childminding.

Harm Each client was paid $20 for time spent participating in either the focus groups or the individual interviews. The ANU ethics committee was concerned about the effects of financially reimbursing clients who may continue to engage in illicit drug use. While these concerns are real, they are nonetheless impossible to substantiate. Moreover, it is a common practice to provide monetary compensation to participants in drug research (e.g. Bell, Ward, Mattick, Hay, Chan & Hall, 1995). This said, it is possible that payment may have biased the sample by attracting those with lower incomes, who are more likely to be clinic based clients.

Conclusion

This chapter has outlined the plan of the research project and the decisions about methods and their ethical execution that necessarily flow from it. In short, the three studies constituting the plan aim to describe the characteristics of the SAHS opioid replacement therapy program; the profile of its clients; and the effect of these on client evaluations of treatment and subsequent client responses to treatment. Approaching the analysis of client satisfaction in this way has several implications. First, examining the
effect of expectancy disconfirmation on client behaviour suggests that the management of client expectations may have visible or material consequences in the treatment sphere. Second, the plan focuses on the treatment’s structure in addition to individual client experiences. This means that the project can not only clarify the question of what constitutes client expectations but utilise a systematic and holistic strategy for answering why they may operate as they do on satisfaction judgments where an analysis of client attitudes or behaviours alone may produce complex or contradictory results. Finally, explanations about the operation of client expectations can include descriptions of their real world effect on not only individual client behaviour but the operation of the program.

A key consequence of planning the research in this way was shown to be a requisite degree of methodological pluralism. Elucidating this meant specifying the balance between the theoretical and empirical inputs to the research and defining their respective roles. It also involved elaborating, and justifying the use of, a variety of operational methods pertaining to sampling and data collection and analysis. The consideration of these issues in addition necessitated the principles for their ethical use to be specified. The three empirical studies forming the basis of this research plan are reported in the following four chapters.
Chapter 5 – Setting the Context: An Assessment of Program Parameters and Service Provider Philosophy

The existence of a national policy and clinical guidelines for providing opioid replacement therapy in Australia implies that there is consensus on what constitutes treatment for opioid dependence, what the appropriate dimensions of the treatment are and how it should be delivered. Having clearly articulated statements in this regard is important because, as was argued in Chapter 4, the development of client expectations of treatment is bounded by the framework of rules and regulations governing the operation of the treatment program as a social institution. However, the large-scale evaluations of treatment processes discussed in Chapter 2 have revealed that programs with similar objectives may vary widely in their characteristics and, therefore, effectiveness (Ball & Ross, 1991; Bell et al., 1995). As such, part of understanding how clients of the Southern Area Health Service (SAHS) opioid substitution program engage with and evaluate treatment requires a description of the components of the particular treatment setting they encounter and the approach of the providers who deliver their care. Providing such a description is the general aim of the current chapter.

Until recently, analyses of the structure and organisation of programs have been relatively neglected in assessments of the effectiveness of opioid replacement therapy. Although conceptual models of treatment structure and processes have been developed to cater for the growing research interest in the area (eg. Etheridge & Hubbard, 2000), the Ball and Ross (1991) study continues to remain one of the most comprehensive evaluations of program and service variables in opioid replacement therapy. In it, 89 variables used to describe the treatment and clinic environments of six methadone programs in North America were classified according to seven characteristics. These were the program’s relationship to the community; its physical layout; the aggregated characteristics of its clients; the characteristics of its staff; the types of services that were provided; its mode of administration and resourcing; and its treatment policy and rationale. More specifically, the program’s relationship to the community was assessed using variables measuring the approach to client loitering, drug sales and theft in the local area. Its physical layout was assessed by documenting the location of the treatment
facility and its security features. The characteristics of clients assessed on an aggregate level were the number of clients in treatment at any one time and their average length of time in treatment. The characteristics of staff that were examined included their years of experience in the program, professional background and level of training and level of involvement with clients. The assessment of services provided included their type, dispensing practices, hours of operation of the service and rules of attendance for each client. The mode of administration and resourcing of each program was assessed by measuring features such as the years of operation of the program, its funding source and its system of managing client records. Finally, the assessment of treatment policy involved an analysis of federal and state laws and guidelines for the operation of the program as well as its orientation to treatment, such as short-term or long-term care. This seven-point format adopted by Ball and Ross (1991) provided the basis for a description of the SAHS treatment environment.

In addition to the structure and content of treatment, the nature of the relationships between clients and service providers has been recognised as exerting an important influence on determining appropriate standards of care (Bell, 2000; 1998). Several decades of research on the effectiveness of substance use disorder treatment generally indicates that the interpersonal functioning and attitudes towards clients of frontline clinicians exerts a major influence on client retention and treatment outcome (see Najavits, Crits-Christoph & Dierberger, 2000 for a review). More specifically, the capacity of service providers to build positive relationships with clients is likely to increase client compliance with treatment while negative encounters by either party may serve to complicate clinician judgments or result in clients defaulting from treatment (Simpson et al., 1995).

The effect on client outcomes of the quality of the relationship between clinicians and clients has been heavily researched in the field of psychotherapy through the concept of the therapeutic working alliance (Bordin, 1994; Martin, Garske & Davis, 2000). From a theoretical perspective, a positive therapeutic alliance between service providers and clients has three dimensions (Bordin, 1994). First, it involves an agreement between the clinician and client on the goals or objectives toward which the
treatment is directed. These usually relate to the client's life struggles and frustrations, about which the therapist helps the client see new possibilities. Second, the alliance is based on an agreement about the tasks of the treatment, which are the specific activities that the client must engage in to experience change in the treatment. Third, there must exist an affective bond between the client and therapist such that the client feels understood, respected and valued in the therapeutic relationship. All three elements of the alliance influence one another in an ongoing way. The quality of the affective bond impacts on the extent to which tasks and goals can be agreed upon, and the ability to negotiate an agreement on the tasks and goals of therapy affects the quality of the bond.

A recent review of the drug treatment literature suggests that the therapeutic alliance is a reliable predictor of client engagement and retention in substance abuse treatment programs, especially for clients with comorbid psychiatric problems (Meier, Barrowclough & Donmall, 2005). While such work has been typically concerned with assessing the value of counselling programs in drug abuse treatment (e.g. Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985; Tunis, Delucchi, Schwartz, Banys & Sees, 1995), the concept is potentially useful for analysing the therapeutic quality of the brief, everyday structured clinical encounters that arise between clients and a range of staff at a drug treatment site. The reasons for this are threefold. First, despite the fact that essentially procedural or decision-making processes predominate in the delivery of opioid substitution therapy—such as, for example, the setting of dose levels or the number of takeaways—the therapeutic alliance stresses the mediating influence of the affective relationship between the client and service provider on the acceptability to the client of these technical elements of treatment. Second, because the technical interventions can only be understood in the relational context in which they arise, the tasks of the treatment, such as dosing, can be usefully engaged in by clients only to the extent that they are meaningful to them. Third, the alliance highlights that much clinical decision making, such as around treatment goals, is the result of a process of negotiation between clients and service providers. As such, an assessment of the therapeutic alliance between clients and the key service providers in their treatment is useful in
determining the extent to which the rules and rituals of a treatment program can be individualised and client-centred.

As indicated above, the therapeutic alliance has been typically assessed to determine its effect on client outcomes in substance abuse counselling programs. Given its usefulness as a treatment outcome indicator, other research programs have been employed to identify the determinants of a positive alliance in these programs, such as clients’ and therapists’ demographic characteristics or client motivation (Meier et al., 2005). In both forms of research, the alliance is usually assessed on individual therapy sessions using one of a range of reliable, standardised self-report scales for clients, therapists and/or independent observers of the treatment. These are aimed at quantifying the degree to which clients are perceived to experience therapists as helpful and supportive and the degree to which clients are considered to be working with their therapist against what is impeding them (Martin et al., 2000).

While much of this research demonstrates that a positive alliance between clients and treatment staff improves treatment effectiveness, with few exceptions (Lilly et al., 2000; 1999) there has been little research aimed at identifying the ingredients of such relationships in opioid substitution therapy or the means by which they are maintained. Moreover, little is known about the approach of key treatment providers, such as prescribers, case workers and dispensers, to building a therapeutic alliance with clients and dealing with the tensions that inevitably arise within that alliance. In particular, it is unclear what service providers consider are the major tasks or goals of treatment and how they collaborate with clients to reach agreement about them. The literature reviewed in Chapter 2 indicates that, despite the adoption of an official policy of harm minimisation and a strategy aimed at stabilising clients through long-term maintenance therapy, service providers may implicitly encourage clients to set a treatment target of abstinence from all drugs. It is therefore important to identify the degree to which clinicians continue to consider client abstinence an appropriate goal of opioid replacement therapy and how they manage any disagreements with clients over this issue. Finally, it is unclear how service providers establish and maintain a positive affective connection to clients, particularly under emotionally stressful conditions. An
exploration of the attitudes of SAHS providers to these issues was considered relevant in providing a description of the SAHS program. It also represents an initial attempt to map the features of the working alliance that develops between treatment providers and clients in the everyday operation of opioid replacement therapy.

The study reported in this chapter has three specific aims. The first is to describe the characteristics of the treatment program and services received by the sample of clients in the SAHS who are the subject of investigation in chapters 6 to 8. The second is to describe the treatment philosophy of the key clinic and community based service providers in the SAHS—namely, prescribers, dispensers and case workers—who work with these clients. The final aim is to identify the approach of a range of practitioners skilled in opioid replacement therapy to building and managing therapeutic relationships with clients.

Method

Documentary Analysis

A description of the SAHS opioid replacement treatment program was derived from an analysis of the 2003-2004 Southern Area Health Service annual report (Southern Area Health Service, 2004); the New South Wales methadone maintenance treatment clinical practice guidelines (New South Wales Health Department, 1999); the information provided to clients regarding the rules of operation of the program’s public clinic (Southern Area Health Service, 2003); and records of interview with the director and clinic manager of the SAHS Opioid Agonist Treatment Service (Southern Area Health Service, personal communication, 28 June 2002; 6 August 2002; 5 August 2005). The analysis involved summarising the documentary material according to the seven central planks of program and service delivery identified by Ball and Ross (1991) as necessary for a comprehensive evaluation of a treatment service. The aim of the analysis was to highlight the unique features of the SAHS opioid substitution program so that it could form a benchmark against which client reports of their subjective experiences of treatment could be assessed.
Interview: Design

Given that the investigation of the service providers' treatment philosophy was generally exploratory in that it was unclear how the providers managed relationships with clients, semi-structured qualitative methods of data collection were employed. Open-ended individual interviewing conducted with the use of a schedule was considered the most appropriate method of gathering information. Such an interview schedule contains a checklist of subject areas, specific questions about which the interviewer can adapt to the particular respondent in the context of the interview. The subjects need not be explored in any particular order. As such, the interview develops spontaneously in the form of a conversation. The guided interview approach has the advantage of focusing and systematising the issues to be considered across a range of participants yet it allows individual perspectives and experiences to be conveyed (Patton, 1990).

A 'critical case' sampling strategy was employed to select suitable respondents (Miles & Huberman, 1994). Three weighted criteria were used to determine suitable cases. Only the first was deemed essential. First, the treatment providers needed to have contact with the greatest number of clients sampled in the two studies reported in chapters 6 to 8. Second, for theoretical purposes, it was highly desirable that there be both providers with whom the clients reported having a positive relationship as well as those with whom clients had a more ambivalent engagement. Finally, it was somewhat desirable that the service providers differed in their length of experience in opioid replacement therapy generally and in their training background. In this way, the findings had the greatest prospect of being generalisable to the client sample.

Interview: Participants

Six service providers (two case workers, two general practitioners and two pharmacists) representing both the clinic and community sectors in the three main geographical regions of the SAHS (the Monaro, Coastal and Northern districts) were interviewed for the purpose of describing the treatment philosophy of SAHS staff and identifying the main features of the therapeutic alliance in a drug treatment setting. In order to preserve
confidentiality in such a small sample, the professional profiles of the providers are described in aggregate form only. Four were male and two were female, and their ages ranged from 30 to 70 (mean = 48 years). The average length of time in their current role with the SAHS was nine years (range = 4-19 years). The length of time each provider had worked in their professional speciality ranged from seven to over 30 years. The length of experience of the case workers and pharmacists equalled the average length of experience of peers in similar professional roles within the SAHS. Each general practitioner (GP) had at least four years experience either greater or less than the average for prescribers in the program (Southern Area Health Service, personal communication, 5 August 2005). Two providers, both GPs, had received formal training for accreditation in their role. This training involved the acquisition of knowledge related to the safe prescription of opioids, workshop participation regarding the proper structuring of treatment delivery and a supervised clinical placement.

Table 5.1 shows the composition of the caseload of each participant at the time of interview together with the frequency of contact each maintained with peers in the SAHS. The total number of clients represented by both general practitioners \((n=150)\) equated to the total client population as at June 2003. Accordingly, the number of clients managed by both case workers \((n=80)\) and by both pharmacists \((n=48)\) represented a little over one-half and one-third respectively of the total client population at that time (Southern Area Health Service, personal communication, 5 August 2005). Each of the participants in the two client studies received treatment from at least one of the service providers. As such, the age range and gender ratio of the clients managed by the service providers is similar to the age and gender characteristics of the clients who participated in the main evaluation and which are reported in Chapter 7. While the size of the caseload managed by the case workers and GPs appears to have remained stable during their tenure in the SAHS, both pharmacists reported a steady increase in the number of clients managed over time. This accords with the growing policy emphasis on the development of community based opioid replacement treatments following the National Illicit Drug Strategy in 1997. While both case workers have caseloads of a similar size, there is a sizeable difference in the number of clients treated by each
general practitioner and by each pharmacist. This was largely due to one GP working in two treatment districts instead of one and one pharmacist being based in a city and the other in a small town. The table also shows that case workers and GPs have regular contact with each other, which reflects ongoing treatment requirements for coordinating the renewal of client scripts and transfers. On the other hand, pharmacists consult GPs and case workers on an irregular basis, suggesting that contact is initiated only when there are questions regarding changes to the administration of the treatment.

Table 5.1 Clinical Caseload and Frequency of Peer Contact of Service Providers

<table>
<thead>
<tr>
<th>Provider</th>
<th>Role</th>
<th>Number of Clients</th>
<th>Client Age Range</th>
<th>Client Gender Ratio</th>
<th>Change in Caseload</th>
<th>Frequency of Contact with Service Provider Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Case Worker</td>
<td>40</td>
<td>20-60</td>
<td>66% males</td>
<td>No change</td>
<td>Minimum fortnightly</td>
</tr>
<tr>
<td>B</td>
<td>Case Worker</td>
<td>40</td>
<td>18-55</td>
<td>66% males</td>
<td>Decreased slightly</td>
<td>Minimum fortnightly</td>
</tr>
<tr>
<td>C</td>
<td>Prescriber</td>
<td>30</td>
<td>18-50</td>
<td>50% males</td>
<td>No change</td>
<td>Minimum fortnightly</td>
</tr>
<tr>
<td>D</td>
<td>Prescriber</td>
<td>120</td>
<td>20-50</td>
<td>50% males</td>
<td>No change</td>
<td>Minimum fortnightly</td>
</tr>
<tr>
<td>E</td>
<td>Dispenser</td>
<td>30</td>
<td>20-55</td>
<td>75% males</td>
<td>Increased</td>
<td>As required</td>
</tr>
<tr>
<td>F</td>
<td>Dispenser</td>
<td>18</td>
<td>25-49</td>
<td>66% males</td>
<td>Increased</td>
<td>As required</td>
</tr>
</tbody>
</table>

Interview: Materials

An interview schedule, shown at Table 5.2, was developed based on three broad subject areas considered relevant to the providers' approach to clients: first, their personal training and experience in the area; second, the nature of their current caseload; and, third, the issues they considered most important in working with clients on a day-to-day basis. The approach to the third topic was based on critical incident analysis, which is a set of commonly used procedures in organisational psychology for assessing individual
reports of incidents involving important facts about behaviour in specific situations (Flanagan, 1949.) Incidents identified as critical by respondents are explored by obtaining a description of the situation, an account of the behaviour of the key players involved, and the reasons the situation is considered important. Incidents are typically reported to highlight examples of effective or ineffective actions.

Table 5.2 Interview Schedule for Service Providers

<table>
<thead>
<tr>
<th>1. Background Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, position title</td>
</tr>
<tr>
<td>Length of time in position,</td>
</tr>
<tr>
<td>Other work commitments (eg. Concurrent roles)</td>
</tr>
<tr>
<td>Reason for entering current role, background training and roles</td>
</tr>
<tr>
<td>Training for position – formal, informal. Was it adequate? Why/why not?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Job Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client profiles – gender, age, number, changes in caseload size</td>
</tr>
<tr>
<td>Assessment method, if any – client referral sources. Acceptance criteria, if any.</td>
</tr>
<tr>
<td>Services provided in role</td>
</tr>
<tr>
<td>Contact with other service providers - frequency</td>
</tr>
<tr>
<td>Approach to regulations. (eg. dose setting, takeaways, transfers, urine testing)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Nature of Client Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant or memorable incidents or aspects of working with clients—positive or negative—especially where challenging scenarios involved, such as pressure to be flexible yet work within rules.</td>
</tr>
<tr>
<td>Probes – describe event, how it was managed and success of outcome; service provider’s understanding of event and how this may have impacted on dealing with it in future with same or other clients and on perception of role – changes in approach over time</td>
</tr>
</tbody>
</table>

Interview: Procedure

Upon the completion of the client interviews reported in Chapter 8, service providers matching the selection criteria were invited directly by the researcher on an individual basis to participate in the study. Of the seven individuals approached, one declined
because of time constraints and workload pressures. The remaining six interviews were conducted between May and August 2004.

Each interview was conducted at the work site of the service provider and lasted between one to two hours. Four interviews were conducted during a break in the provider’s standard working day, and temporary interruptions from the workplace occurred in three of these interviews. At the beginning of each interview, the participant was instructed that the interview sought to obtain their views on the most significant features of their working relationship with clients and advised that the study was part of a larger project examining client experiences of treatment. The respondents were verbally reminded of the confidentiality and anonymity of their responses. All interviews were digitally recorded on a laptop computer using Sound Forge XP 4.5 audio editing software (Sonic Foundry, 2000).

Each interview was transcribed verbatim by the researcher using RapidWrite Pro 1.02 (Stenograph, 2001) shorthand translation software and analysed using N6 (Qualitative Solutions and Research, 2004) qualitative data software. The data analysis strategy employed reflects the approach advocated by Miles and Huberman (1994), which utilises a combination of inductive and deductive methods to reach conclusions about the topic under investigation. According to this approach, qualitative data analysis is partly inductive inasmuch as key themes and issues are allowed to emerge from the data rather than be examined according to predetermined hypotheses. In this way, the complexity and relativity of issues can be respected and researchers are not blinkered to the important issues in a setting or likely to misread the meaning of informants’ perceptions (Glaser, 1992). However, structured conceptual designs are also used in order to focus and systematise data analysis, particularly when participants from different groups are studied (Miles & Huberman, 1994; Strauss & Corbin, 1990). This more confirmatory qualitative design also makes explicit the influences guiding the research and, therefore, category construction. As such, it does not presume that the categories emerge naturally from the data or that the knowledge and interests of the researcher play no role in shaping analytic decisions (Strauss & Corbin, 1990).
Being descriptive in nature, the study aimed to simply explicate the issues service providers considered important in their working relationships with clients, not identify the deeper causal mechanisms underlying their existence. As such, a largely inductive content analytic design was employed. The main theoretical components of the therapeutic working alliance—namely, the negotiation of tasks and goals and the establishment of an affective bond (Bordin, 1994)—were employed for the purpose of organising the themes and, therefore, simplifying the final analysis. This conceptual frame was considered broad enough to accommodate the respondents' understanding of the important issues on their terms.

The data analysis was conducted in two stages. The first stage of analysis utilised an inductive approach to the data, where codes were developed through the grounded theory method of open coding (Strauss & Corbin, 1990). This involves examining each sentence of the transcript, typically within the context of each paragraph, and attaching a descriptive code to the actions or events representing it. These codes serve as a shorthand label to enable the separation, compilation and organisation of the data. A total of 262 concepts was generated from this process. These concepts were then clustered into 28 themes based on the frequency and similarity of participant references to various aspects of their experience, including aspects of their personal background, features of their caseload and issues of significance in their relationship with clients. Appendix A lists each of these themes and the concepts it describes.

The second phase of analysis involved sorting common themes into higher-order analytic categories. The aim of this process is to search for core categories that can account for the most variation in the data (Glaser, 1992). Each theme was categorised according to the three components of the therapeutic alliance. The categorisation of the 28 themes according to the various elements of the alliance is displayed as a matrix in Appendix B. In the final analysis, the themes in each category were reviewed so that items represented by similar themes could be clustered into more abstract categories and new themes containing distinctive ideas could be created. A total of 18 themes emerged from this process. The representativeness of each theme was then obtained by checking
its occurrence against the experiences and opinions reported in each respondent’s transcript of interview.

Following this process, the respondents were invited by email to comment on the accuracy of the analysis by indicating the degree to which the results reflected their experience. To preserve confidentiality, each participant was sent a copy of the complete results section but with only his or her quotes included in the relevant section of text. However, the participants were invited to comment on any aspect of the conclusions, including those where they may not have been directly quoted. They were also asked to add any information not yet addressed which they considered relevant for providers in managing relationships with clients. On the basis of this process, no alterations or additions to the results were requested by any respondent.

Results

The results are presented in two sections. The first section describes the characteristics of treatment policies and procedures in the SAHS opioid replacement therapy program, such as its size and setting; staff characteristics; services; and clinical guidelines. The second section identifies the key themes driving the approach to treatment of a sample of key service providers in the program. The purpose of these results is to describe the program and the treatment philosophy of principal SAHS staff to provide a context for the client reports of treatment that appear in later chapters.

The Assessment of Treatment Parameters

Program Layout and Relationship to the Community

At the time of the client studies in 2002 and 2003, the Opioid Agonist Treatment Service was one of eight programs within the Alcohol and Drug Service of the Southern Area Health Service. The program commenced in August 1994. It covers a geographically diverse area of over 52,000 square kilometres in south-eastern New South Wales and caters for a general population of over 194,000 (Southern Area Health Service, 2004). As shown in Figure 5.1, the Opioid Agonist Treatment Service can be classified into three treatment districts. The first, the Monaro area, encompasses the
small cities of Cooma and Queanbeyan, the latter of which, with a population of approximately 33,000, contains the headquarters of the program. The second, the Coastal district, serves the seaside towns of Batemans Bay and Moruya. In 2003, services in this district were extended to include the town of Bega. The third, the Northern district, includes the small city of Goulburn and the township of Yass.

Figure 5.1  Map of the Southern Area Health Service.


The program contains one clinic located in a residential area of Queanbeyan that is dedicated to the free provision of daily opioid substitution treatment for clients resident in that city. Two local pharmacies also provide dosing, for which clients pay a dispensing fee of $5 per day. The remainder of the program is administered through community health centres adjoining hospital campuses in each of the centres listed above and 24 pharmacies encompassing outlying towns and villages, where clients pay
a dispensing fee ranging from $2 to $5 per day. Takeaway doses are available at all pharmacies. Free daily hospital dosing is available for less than 10 per cent of clients in the town centres (Southern Area Health Service, personal communication, 6 August 2002). All prescription services are bulk-billed through Medicare.

The Queanbeyan clinic, known as the Crossroads Clinic, operates out of a converted house and is identifiable only by a small sign indicating it is the site of the Alcohol and Drug Service of the SAHS. While the clinic maintains locked entrances at all times and is monitored by a security company, these security features do not appear to inhibit staff and client interaction. Staff have access to duress alarms when in the common areas of the building. In 2005, video monitoring of the exterior of the clinic was introduced (Southern Area Health Service, personal communication, 5 August 2005). In the dispensary, staff are separated from clients by a counter with a glass partition. Client flow from the waiting room into the dispensary and out of the building is controlled by staff via electronically locked doors. Newly enrolled clients are informed in writing that their language and behaviour around the clinic should be appropriate for a public area and residential zone and that they are not to congregate after dosing. Signs reminding clients of this rule are also on display in the dosing area (Southern Area Health Service, 2003).

Client Population Profile

Table 5.3 shows the total number of clients in each of the three treatment districts of the Opioid Agonist Treatment Service as at June 2002. The clients are classified according to whether they receive free daily dosing at the public clinic or hospitals (‘clinic clients’) or whether they pay for doses to be dispensed through a local pharmacy, where takeaway doses may be obtained (‘community clients’). As is shown, almost two-thirds of clients in the Monaro district receive services through the public clinic while over 90 per cent of clients in the less populated Coastal and Northern districts access treatment though their local pharmacy.
Table 5.3  Number of Clinic and Community Based Clients in the Opioid Agonist Treatment Service by Treatment District as at June 2002

<table>
<thead>
<tr>
<th>Treatment District</th>
<th>Number of Clinic Clients</th>
<th>Percentage</th>
<th>Number of Community Clients</th>
<th>Percentage</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monaro</td>
<td>50</td>
<td>60.2</td>
<td>33</td>
<td>39.8</td>
<td>83</td>
</tr>
<tr>
<td>Coastal</td>
<td>3*</td>
<td>6</td>
<td>47</td>
<td>94</td>
<td>50</td>
</tr>
<tr>
<td>Northern</td>
<td>5*</td>
<td>10</td>
<td>45</td>
<td>90</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>31.7</td>
<td>125</td>
<td>68.3</td>
<td>183</td>
</tr>
</tbody>
</table>

* = hospital dosed

Source: Southern Area Health Service, personal communication, 28 June 2002.

Total client numbers in the program in the last three years are estimated to have ranged between 150 to 230 (Southern Area Health Service, personal communication, 5 August 2005). In June 2002, the total number of clients in the program was 183. By June 2003, it had fallen to 150. However, by June 2005, the number had increased to 229. Table 5.4 shows the number of methadone and buprenorphine clients in New South Wales in 2003. Based on the 150 clients enrolled in 2003, it can be seen that the SAHS program represented approximately 5.6 per cent of the total rural New South Wales treatment population of 2,600 for that year.

Table 5.4  Number of Methadone and Buprenorphine Clients in New South Wales by Region of Treatment and Gender, 2003

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>6,776</td>
<td>4,095</td>
<td>10,871</td>
</tr>
<tr>
<td>Rural</td>
<td>1,555</td>
<td>1,105</td>
<td>2,660</td>
</tr>
<tr>
<td>Justice Health *</td>
<td>1,242</td>
<td>230</td>
<td>1,472</td>
</tr>
<tr>
<td>New South Wales</td>
<td>9,573</td>
<td>5,430</td>
<td>15,003</td>
</tr>
</tbody>
</table>

* = treatment population in prisons


By June 2004, approximately one-third of SAHS clients were receiving buprenorphine.

No statistics are retained on the length of time clients remain in the program.
Staff Profile

As at June 2002, there were three general practitioners providing prescription services; 10 alcohol and drug professionals providing case management and clinic dosing services; two nurses providing clinic dosing services; and 24 pharmacies providing dispensing services in the program. The average length of employment in the service is five years for case managers and eight years for prescribers. While the expected staff to client ratio for case managers is 1:25, recurrent shortages of these staff, who are often registered nurses, have meant that the ratio has risen to as high as 1:50. In 2003, there were four vacancies for full-time case workers in the program. In such circumstances, the provision to clients of ancillary services such as counselling and social liaison work is often curtailed. Stabilised clients receiving basic opioid substitution treatment have minimum three-monthly contact with both their case worker and prescribing doctor.

While specific training in drug and alcohol treatment is not an essential requirement for employment, case workers engage in case reviews through peer supervision with a senior clinician on a fortnightly basis (Southern Area Health Service, personal communication, 6 August 2002; 5 August 2005).

Service Provision

At the time of the client studies, the Crossroads Clinic provided once-daily dosing from 7.10am to 9.50am on weekdays and from 10.10am to 12.50pm on weekends and public holidays. In 2005, the closing time of the clinic was moved forward 10 minutes to account for changes in staff hours related to the dispensing of buprenorphine. Dosing at all pharmacies is undertaken at any time during store opening hours. There are generally no time restrictions on hospital dosing. Given the small client numbers dosing at the Crossroads Clinic, buprenorphine and methadone clients are dispensed in the one area. No takeaway doses are available from the clinic or the hospitals. Newly enrolled clients are assigned to daily clinic or hospital dosing and may be transferred to the community sector after at least a month of demonstrating regular attendance at appointments, a lack of intoxication and appropriate social behaviour.
Temporary transfers to other dosing sites can be arranged within a week for New South Wales travel and within three weeks for interstate travel. Client consultation with case managers and prescribers over these and other issues, such as counselling, occurs within standard business hours. Each prescriber attends at the clinic or community health centres one day per fortnight to provide script renewals. Clients who do not attend for dosing, script renewals or reviews with their case manager may lose takeaway privileges, receive a reduced dose or be excluded from the program. Urine tests are conducted randomly for monitoring client stability, and there are no penalties for those showing signs of illicit drug use. Clients found to be diverting doses or engaged in illicit drug sales, however, face expulsion from the program following an initial written warning and the removal of takeaway privileges (Southern Area Health Service, 2003). Community based clients involved in threats of violence, the intimidation of customers and theft from pharmacies are transferred back to the clinic or hospitals for dosing.

Administrative and Policy Framework

With an orientation towards indefinite maintenance treatment based on a policy of harm minimisation, the Opioid Agonist Treatment Service receives recurrent funding from the New South Wales state government for its administration. Prescription costs are met by the Commonwealth government through Medicare. Despite a significant increase in funding following the Drug Summit in 2000, the program incurred an additional cost with the introduction of buprenorphine dosing at the Crossroads Clinic in 2003, where extra staff hours were required to meet the extended dispensing time associated with the drug (Southern Area Health Service, personal communication, 5 August 2005). This was partly offset by a policy initiative aimed at increasing the number of stabilised clients referred to private pharmacies. In line with the clinical guidelines for opioid maintenance treatments in New South Wales, newly released prisoners, pregnant women and those with HIV are accorded priority entry to the program. Waiting time for admission to the program is approximately one week.
The Assessment of the Therapeutic Alliance

The results are organised according to the three general components of the therapeutic alliance between service providers and clients: task collaboration; goal setting; and the affective bond. A core theme, described in the form of a dynamic tension that arises in the relationship between the service provider and client, is outlined in relation to each of these components. This is followed by a taxonomy of provider responses to its main features. Direct quotes from the respondents are provided to illustrate these challenges and their responses.

Collaboration: The Management of Treatment Responsibilities

A complex challenge for service providers working with opioid dependent clients is negotiating the role of each party in achieving an improvement in the client’s wellbeing. All respondents spoke of demanding encounters with clients where the clients were emotionally stressed and seemingly unable to take responsibility for themselves. These situations represent a threat to the provider’s sense of control in the relationship with clients and invite the provider to assume additional responsibilities to ensure the welfare of the clients and restore social equanimity. Responding to this invitation to extend the provider’s responsibility for the clients, however, poses a risk to the long-term ability of clients to develop self-control in crises and, with it, self-esteem regarding their capacity to cope with problems. This GP’s account highlights the tension invoked when a provider is called on to revoke takeaway privileges, for example, because it is unclear to what extent the client is capable of assuming responsibility for them:

The problem is that I find myself very often to be judge and jury, which I hate to be, or a policeman. There is a lot of gossip. Somebody tells you that X is injecting, so you confront X and of course it’s denied, you know. So you are forced to make judgments which are really judge and jury. If it’s a formal complaint from a pharmacist that [the client] sort of misappropriated a dose, that’s it—it’s clear-cut; you just act on it, and that’s it. But it’s these sort of marginal things. Even if you tend to accept it as true, which it very often is, you feel a bit silly because it’s not really my role to be a big daddy or a teacher or a policeman and say, ‘You will get it. You won’t get it.’ It’s a difficult position. It’s a controversial situation...Again, in most cases until now, it always somehow resolves. It can be a bit uncomfortable. (Provider D)
Response 1: Understand the realistic limits of the provider’s role. Two respondents reported that reflecting on the realistic limits of their role was one means by which to restore perspective in negotiating with clients over issues of treatment responsibility. One participant explained this by delineating the provider’s capacity to cure the problem versus facilitate the client’s ability to deal with the problem. This required the adoption of a more responsive approach to handling client treatment needs rather than an active one driving client change:

Because I think always that my role is to give them an opportunity to get well. If they don’t want to get well or if they haven’t got the personal resources, despite whatever help I am able to offer or the staff are able to offer down there, then it’s not going to happen. I’m not going to be the one that gets them well, you know what I mean. I mean, that’s very much an individual responsibility that they have. (Provider C)

Response 2: Communicate to clients how they can take control. Several respondents reported that showing clients how they were ceding control in times of stress enabled the clients to consider alternative responses to their problem and, by default, take responsibility for it. This was accomplished by highlighting to clients that the key to resolving problems is not completely located in external circumstances, such as the actions of a powerful authority, but at least partly in their own attitudes and behaviour. Importantly, this needed to be done without attacking or brutalising the self-esteem of the clients in reflecting on their predicament with them. The benefit for the provider is a feeling of being released from the ‘emotional manipulation’ of clients wanting to be rescued from problems for which there are no quick and simple solutions. One participant reported success in tackling a client’s expressed sense of helplessness in the following way:

...you know, when they try to say, ‘Oh, well, if you don’t give it to me, then I’m going to use’, I say, ‘Well that’s your choice, you know.’ I think that is a good way of deflecting that sort of issue. Because I guess a lot of people who’ve been drug users are victims or like to play the victim. And I’ve got one guy who actually comes and sees me in [dosing location] now. You know, just the problems he had were always somebody else’s fault, you know...But I think that, you know, he’s certainly wanted to blame everybody else and the world for his problems. But I just kept on saying, ‘No, you’re the one that has to deal with it.’ So I think you can do that in a caring way. (Provider C)
Response 3: Be mindful of public health responsibilities. All the respondents alluded to their duty to protect public health and safety in the program in determining the limits to which they could reasonably respond to the needs of individual clients. For prescribers, this responsibility principally, but not exclusively, concerns minimising the potential for the diversion of takeaways; for dispensers, it involves curtailing service to intoxicated or socially aggressive clients; and for case workers it concerns ensuring clients regularly attend for program reviews, script renewals and clinic dosing. The respondents identified clients' ongoing preparedness to abide by fundamental responsibilities regarding their behaviour in these domains, outlaid at the time of their admission to the program, as the final determinant of whether they would continue to provide treatment. Several participants indicated that balancing the needs of individual clients against broader public health risks in deciding whether to offer treatment was especially difficult at the beginning of treatment, when little is known about the client. In speaking on this topic, one GP said:

And then I think that the public health aspects of takeaways are the other really important aspect and how you balance the public health risks associated with takeaways with the benefit that you’re giving to another person by giving them that independence and freedom and respect and, you know, opportunity to be in normal life again. And I think that’s a real sort of struggle, depending on the individual and how far they are along that sort of road and whether they’re along that road at all—they’re just scamming you most of the time and using most of their takeaways as a bit of income. (Provider C)

Explaining to clients the need for both parties to attend to the public health risks associated with the program in order to ensure the continued availability of treatment for the client population generally also helped diffuse tensions in the relationship between individual clients and the service provider over the issue of personal responsibilities in particular situations:

So [discussing the public health elements] is to try to not involve them but help them to see the rationale behind it and to take it away from being a personal attack on them... From my point of view, the reason I do that is because it does take it away from a me-versus-you approach and I think it introduces a fairly objective sort of ‘Yeah, this is how anyone needs to handle this situation’. (Provider C)
Response 4: Outline to clients the likely consequences of their choices in treatment. Several participants spoke about establishing a contract with a new client outlining the rights and responsibilities of either party in participating in the program at the local treatment site. The terms of the contract would be consonant with the broader legislative guidelines applicable to all clients of the program but be tailored to the daily requirements of the particular treatment setting and cover issues such as dosing times and appropriate forms of client behaviour at the dosing site. The interview participants reported that deadlocks with clients over issues involving irresponsible client conduct as defined by the contract could be potentially remedied by warning clients, either verbally or in writing, of the likely risks to their ongoing treatment by continued participation in the problematic behaviour. Further, it was important that clients realise they could choose to remain in treatment by honouring the terms of the contract while voicing disagreement with some aspects of it; in this way, providers and clients could arrive at a settlement of the issue by agreeing to disagree. For two providers, clients’ open expression of their disapproval of elements of the contract was cited as an important influence in the ‘evolution’ of the contract terms. In this way, the development of the contract was ultimately a collaborative exercise, not one involving the outright domination of one party over another. The usefulness of a contract was highlighted in the following way:

I mean, it’s one of the great things about the contract nature of things—is that those sorts behavioural issues are pointed out in the contract, and ‘You will behave appropriately and you will not abuse people, and if you do, then you’ll be put off the program.’ And nearly all the time once people have gone through that again, they’re able to restrain themselves, it seems, because they know that their methadone supply is going to be cut off. And they’ll try to say, ‘Oh, you’re making me do this’, and then you just put the responsibility back on them—‘Oh, no. We’re very happy to provide you with methadone as long as you abide by these perfectly reasonable human conditions’, you know. (Provider C)

Response 5: Communicate directly with other service providers. Three providers spoke of the benefits of knowing the limits of their colleagues’ role as well as their own and of the importance of those roles being complementary, if not consistent, when deciding how to deal with unanticipated requests for assistance by clients. The respondents reported that it was easier to be clear about their responsibility for
admonishing a client’s request when they knew that their judgment would not be undermined by a client’s successful appeal to a colleague on the same issue. The need for treatment professionals to communicate directly, not via clients, to ensure that all providers are operating according to similar principles is highlighted in the following example:

Oh, well, they used to play [business partner] and I off against one another. You know, they’d come in to [business partner] and say, ‘Well, [Provider E] does it for me.’ Then I’d be here and they’d say, ‘Well, [business partner] does it for me.’ You know, that used to go on. Or things like, um, ‘Oh, it’s been organised’ or, ‘No, I spoke with the doctor. It’s all right’, this sort of thing. But what we’ve basically done is said, ‘If we haven’t got a script, you don’t get it.’ I mean, they come in and they say, ‘I’ve had another extra takeaway authorised for Tuesday’ or something, and we just say, ‘Well, I haven’t got a script.’ They say, ‘Well, I spoke to the doctor. Will you ring a doctor?’ And I say, ‘No. We won’t ring a doctor for you.’ (Provider E)

Treatment Goals: Understanding the Nature of Addiction

All the respondents reflected on their playing a consultative rather than a directive role in responding to clients’ requests for treatment. In particular, this involves providing clients with information and guidelines regarding a range of treatment options based on each client’s personal goals in the program and his or her capacity to achieve them. One rationale provided for this approach is that clients are considered more likely to achieve successful outcomes from the service if their treatment aims are self-determined or ‘owned’ by them rather than imposed upon them by providers.

A challenge for service providers in adopting this stance, however, lies in reconciling any difference between their understanding of the treatment’s potential and clients’ achievement of goals. This may arise in two ways. First, clients may show considerable ambivalence about their goals by expressing a desire for a specific realistic outcome yet acting in a manner designed to directly undermine its fulfilment. As such, they fail to achieve an expectable result and show little improvement or positive change. Second, clients and service providers may use different criteria to define a successful treatment outcome. For example, clients may join the program with the aim of becoming abstinent of all drugs, including the pharmacotherapy, in the long term while
the service provider may consider that minimising the ill-effects of the clients’ illicit drug use in the short to medium term is indicative of a positive result.

Where service providers adopt an abstinence perspective to accommodate the goal of the client to live a completely drug-free lifestyle rather than one oriented towards achieving maintenance on the opioid substitute, the achievement of lifestyle stabilisation on the program may come to be considered only a partial or a qualified success. In this way, the intermediate gains offered by the treatment tend to be overlooked or minimised and the risk of treatment failure, defined by the single end goal, is increased. In the study sample, all respondents spoke of the benefits of harm minimisation and the opportunities afforded clients to transform a life of illicit drug use through participation in the program. The following response best summarises this attitude:

But taken in context, you know, if you consider positive outcomes, people cope with family life; and some of them work; and they are free of deep depression or suicidal thoughts; and their hepatitis C is managed reasonably well; you know, that they are coached in lifestyle issues, like nutrition and medical care and all these things. So it’s a success, in my books... (Provider D)

Half the respondents, however, referred to client abstinence from all drugs, even if not probable, as the ideal or final marker of treatment success. One participant expressed it in the following way:

Because success is thin on the ground in terms of being off the stuff completely. The other clients who come in every day and get dosed, those ones I was speaking to you earlier about, they are clean. They are living a straight life. They are not doing crime or other drugs or anything. And, you know, it’s just good to see that happening because it’s—you know, it’s a success, isn’t it [laughs], and you want to have it. (Provider E)

If implicitly focused on long-term outcomes rather than intermediate gains, providers risk disappointment from a perception that clients appear to show no improvement. In the short term, however, a number of small changes are discernible. This creates a dilemma of focus in defining treatment success, which is highlighted in the following account:
Um, because you do what you can for the people in this sort of area, but I think the full-on success stories are fairly few and far between. A lot of the time we certainly do prevent people from further injuring themselves or dying from overdose or whatever; I certainly see that we sort of serve a purpose and a role and do a really good job, but there’s not a lot of job satisfaction, I guess you’d call it [laughs].

Q. In terms of the success stories?
A. Yeah, yeah. I mean, sometimes you can feel as if you’ve had a day or a job well done on a day because you’ve managed to get someone into rehab or you feel as if you got someone over a low period or something or they were feeling really depressed and then at the end of a session they sort of say, ‘Thanks. I feel quite a bit better now and it just helps to talk.’ And you think, ‘Oh, well. I’ve done something good.’ [laughs]

Q. Very small steps, though?
A. Yeah, yeah. And sometimes it is like that. (Provider A)

Conversely, for one participant, the challenge was reconciling client goals of indefinite treatment maintenance with a situation where natural resource limits imposed a constraint on the ability of the program to service an ever-increasing number of treatment applicants. This resulted in the de facto encouragement of clients aiming to achieve abstinence:

So, you know, those two characters have gone back to the methadone withdrawal concept because they had desires to do something different. And they both need to be applauded and supported if they have a crisis. But that doesn’t mean methadone maintenance is bad. But there are some, I reckon, who just get into the routine and that’s where they stay, yeah. (Provider F)

Response 1: Clients have different goals at different stages of treatment. Four participants spoke of the importance of overcoming an initial tendency to assign clients to a category of drug users defined by a single motivation and then to evaluate their responses to treatment according to this standard. Relinquishing this stereotypical thinking required client setbacks in treatment to be ‘normalised’. This occurred by the providers noticing the similarities between clients and members of the general community in the variation of their response to illness and treatment as shaped by a range of psychological and social factors. As a result, clients could be recognised as individuals with different treatment goals and different aptitudes for achieving them at different stages of their recovery, as suggested by this respondent:

But they’re all different. We’ve got ones—I mean, if they’re—if they’re using the program to actually try and control their habit, they’ve got a different attitude to
somebody who’s just using it as an additional drug source or for somebody who is just using it to keep on going between using heroin. So it’s really—they’re all different and their motivations are different. And that varies with their age and what their social circumstances are and all sorts of things—whether they’ve got a job or not. If they don’t have a job, it’s very complicated, as you’d know. (Provider E)

Response 2: Be mindful about conveying personal disappointment to clients. In order to sustain an alliance with clients in the pursuit of goals, one service provider indicated the importance of treatment staff not relaying any personal frustration or dismay to clients at the clients’ failure to achieve agreed upon objectives:

It was disappointing in the end, but you have to learn as a clinician not to pass that on to the client, I guess. Like, it can be disappointing, but you don’t want to be putting them down and making them feel—I mean, they probably feel bad enough as it is, so we have to learn not to transfer that disappointment that we’re feeling on to them.

Q. How do you manage that?
A. Just sort of saying, ‘Oh, look, it’s okay. It’s a relapse. It’s not the end of the world. C’mon, we can work on this. We’ll support you’, and just afterwards debriefing with someone else and sort of saying, ‘Oh, you’ll never guess who I’ve seen again.’ Yes, so just being really conscious of the way in which you speak to the client and what actually comes out of your mouth, I guess. Not too much self-disclosure [laughs] sort of helps as well so that you’re not sort of transferring too much of your feelings into it. (Provider A)

However, the same provider reported that restraint in the transmission of the provider’s personal opinions needs to be balanced against the active encouragement of clients and their capacity to achieve goals:

I think to a point you do transfer it, and particularly as they’re getting towards the end of their treatment. I think in a way you actually need to because it’s part of supporting them and helping them to move on, because you’re encouraging them and you’re sort of saying to them, ‘You’ve done really well. You’re doing a great job and this is just fantastic and it’s going to be so good not to see you again.’ Like, building them up, in that sense, and I think to a point you need to do that.

Response 3: Understand that relapse is inevitable. Half of the respondents spoke of the need to understand the power of clients’ ambivalence about reducing their drug dependence, particularly at times of personal stress. These participants referred to the difficulty clients had in abandoning the reinforcing familiarity of their physiological, emotional and social responses to illicit drug use even while being highly aware of the
negative side effects of their dependence. Once the potency of the difficulty was realised, relapse to illicit drug use was identified as an almost inevitable part of the process of clients’ recovery and eventual achievement of their goals. One service provider explained this realisation in the following way:

So it’s just realising that it’s not that easy. And, like I said, I’m sure I wasn’t quite that naïve, but it’s still something, a thought that crosses your mind, I suppose. It’s sort of like, ‘Well, why can’t they [become abstinent]?’ And then you’re reminded, ‘Oh, right, they’ve got an addiction.’ It’s powerful, it’s extremely powerful and it doesn’t matter what the drug is. (Provider A)

Response 4: Reflect on personal struggles to find connection with the client’s position. One respondent reported that reflecting on the processes involved in a personal struggle to abandon a bad habit helped in developing empathy with, and an understanding of, clients’ apparent lack of change despite their efforts:

I can pick that person up and take them from new again and I never ever get discouraged because, to me, I think addiction is so amazing that sometimes it can take six or seven goes to click. Because I was an ex-cigarette smoker and I’ve been there and it took me a lot of times to give up the smoking. So I have sort of always put that into what they’re trying to do. And I always say, ‘Look, you failed that time. It’s okay. You’ve learnt lots from that time that you were, you know, straight. Let’s pick up some of those skills. We’ll move on and add a few more to this next lot.’ Sometimes you might fail another couple of times, but eventually you’ll get there. And I just never give up. And I’ve got…a community client that’s probably been eight times. But I just would never give up on him. But people can’t understand why. And I’ll still see him if he turns up because I know one day he’ll either die or he will get it. He’ll get the message, mm. Because there is a point where things click and I see it click in people. They say, ‘Oh, I’ve got this. I’ve finally got it.’ And you just wait and you can see that happen and you know that they’re going to make it, yeah. And I like that click.

Q. That keeps you going too?
A. Yes. You get a lot of joy out of that, yeah. (Provider B)

Response 5: Separate the person from the problem. Many participants reported instances of clients appearing to lie or deceive service providers as a way of denying or avoiding taking action on goals they had set themselves. In considering this point, they noted the importance of understanding that while some clients may deliberately intend to deceive, the lying is often not malicious because clients sometimes make false statements believing them to be true. This was especially because
drugs were seen to ‘colour’ their personality and behaviour. As such, while clients could continue to be accepted despite the falsehoods, they need not necessarily be believed or trusted. One respondent indicated that clients also need to learn that they are ultimately deceiving themselves in such circumstances. In speaking about managing the disappointment of being misled by clients, another said:

But I think one of the things that I’m conscious of with methadone is that I guess I’ve learnt to always respect the other person, or try always to respect them, but never entirely trust them, no matter who it is. And so I don’t—I get surprised and disappointed when things happen that I’m not expecting—you know, when people seem to have been going really well and [laughs] then you discover they’ve been injecting all their takeaways for the last six months, that sort of thing—but not to be emotionally affected by that. I’m not sure if that makes sense. And it’s not distancing yourself from the individual, although—but I guess you start—well, I always start the relationship and I think continue the relationship with the knowledge that that person has an addictive feature in their personality and that’s why they’re here in the first place and that’s going to show itself at different times. And so I don’t—I don’t have a negative reaction to that addictive personality displaying itself at times, I suppose. (Provider C)

The Affective Bond between Service Provider and Client: Establishment and Maintenance

A third key challenge for service providers working with clients in opioid replacement therapy is creating trust and confidence in the treatment relationship and then maintaining it at a level that is sufficient to withstand threats or ruptures. Almost all the respondents reported that serious challenges in the development and maintenance of the service relationship occurred with approximately 10 to 20 per cent of clients, who were experienced as uncommunicative, secretive and withdrawn or, conversely, demanding, angry and chronically critical or complaining. Potential difficulties in the client relationship were identified as occurring in the early stages of treatment when clients had not settled into the program and during times of client relapse. On these occasions, service providers reported feeling attacked and relayed experiences of heightened emotional reaction to the clients. The respondents reported that if they had no prior experience of a particular issue, there was a tendency to either gratify the client’s demand, which had the potential to reinforce the behaviour, or exert control and withhold treatment, thereby risking client termination from the program.
Response 1: Learn from the client what is needed. Four respondents indicated that listening with an open attitude in order to learn about the experiences of clients created an environment in which the confidence of both parties in relation to the other could be built. Learning about how clients feel, particularly when under the influence of drugs, enabled providers to understand how and why clients became stressed and how they could be helped in such situations. Two respondents indicated that it was important to allow clients time to reveal their concerns and not to prod for information that may explain their behaviour. In particular, building rapport with clients meant not minimising their feelings or dismissing problems. One service provider expressed the point in this way:

And basically, it’s a reassurance. At the same time you don’t sweep [their] psychiatric problem under the carpet, saying, ‘Oh, you’ll be all right, mate. Piss off’, you know, type of thing. Very often that is what general practice does. It prescribes and does not allow people to get across [the problem], which is how it should be. Q. How important do you think all that element of it is in working with this population? A. I think extremely important, yeah, yeah. Because, look, despite the exterior of the patients, they are people who feel very—how to put it?—intensely about it. They feel intense guilt about this, you know. So, strangely enough, I had to learn it, again probably a part of the prejudice you develop to drugs... So you have to—how to put it?—accept these things and not categorise people or somehow put them into a different category from a nice old lady who has got depression. They might be less pleasant sometimes, you know—[laughs] it’s quite irritating—but their feeling is not any less intensive or blunt. On the contrary, they have much more on their plate than we even imagine, you know. (Provider D)

Response 2: Promote client self-reliance and assertiveness. Half the respondents emphasised the value of providing direct encouragement to clients as a way of building the treatment relationship. Such encouragement includes reminding clients of the extent of their progress in treatment and applauding their efforts to develop and commit to treatment goals. Importantly, the interview participants also described the need for providers to adopt a neutral, non-shaming attitude in response to client setbacks. The need for clients to not feel condemned or abandoned in their efforts is expressed through analogy in the following response:
You know, you can—I mean, if you’re trying to build up a relationship with somebody where you want to improve their sense of self-worth—that sounds a bit patronising and I don’t mean it quite like that, but it’s part of the relationship—then to sort of put them down because they’ve been ‘naughty’ doesn’t help with that. You know, I mean, I see those episodes of relapse—like, I mean, if you’ve got an alcoholic, nobody treats alcoholics that way, you know. They don’t say, ‘You silly bastard. You’ve gone and had another drink and you shouldn’t have.’ And if people start smoking again, they don’t do that. So just because somebody has been injecting themselves again or has given away a takeaway or sold something, you know, I can’t see any reason for treating them that way. (Provider C)

Response 3: Contain emotions in the provider and the client. In considering incidents involving a degree of emotional volatility on the part of the client, such as intoxication, five respondents identified the importance of resisting the temptation to provide a response to the client’s distress based on their own immediate emotional reaction to the situation, be it panic or anger. The providers indicated that being non-reactive to a client’s frustration and, if necessary, delaying a response until the emotion of the situation had subsided meant that they and clients were in a better state to consider and find ways of addressing the issues underlying the incident. On the topic of learning to provide well-timed and thoughtful responses to critical incidents, one respondent made the following point:

I guess, just giving me that more flexible approach and seeing the issues for what they were and dealing with them in a more systematic way than just an emotive, reactive type of way. And I think that’s one of the really important aspects of working with [the clients]. I think you’ve got to be responsive without being reactive, you know what I mean. Because if you’re not, then you don’t have any connection with the person and you’re not thinking about them as an individual. (Provider C)

Response 4: Don’t take attacks personally. Half the interview sample suggested that, in addition to confining their emotional response to client stress, it is important not to take attacks personally if the client-service provider relationship is to be sustained over the long term. These respondents indicated that client outbursts frequently reflect the client’s desperation in a situation. As such, they are an indication that the client is not in a position to consider how his or her behaviour might impact on the provider. Two participants described such situations as opportunities to learn more about the client’s needs. This respondent considered the issue in terms of client skills:
I don’t take it on board because I know it’s not—I don’t take any of that personally. And people say, ‘But how can you do that?’ And I say, ‘No, well, I don’t. It’s their pain. That’s the way they deal with stuff. They haven’t learnt to deal with things like we have, probably. They haven’t got those skills.’ And I never take it personally. I don’t think anything. I can’t think of any one time that I have taken it on board. And a lot of times they don’t remember that it’s happened. And a lot of times it isn’t directed personally. It’s just, ‘You fucking thing. Why don’t you dose me?’ And la, la, la. And sometimes they will remember and they will apologise and you say, ‘Well, that’s okay.’ (Provider B)

Response 5: Being consistent is respectful. Four service providers gave extensive examples demonstrating the importance of behaving consistently and reliably in the treatment of clients. Most spoke of this in terms of the right of opioid substitution clients to receive a level of courtesy, respect and attention equal to that of other clients serviced by the provider. In discussing consistency in behaviour, however, respondents pointed to the need to balance flexibility with reliability. This is highlighted in the following comment:

Understand that it’s a lifestyle situation and that Monday is a different day to Tuesday is a different day to Wednesday in all of these people’s lives as well as it is in your own life and it’s very important that you provide a level of consistent behaviour for the methadone client. And that consistent behaviour also extends to your expectation of them. But provide a sufficient flexibility to create a good relationship but not to create a flexibility that you are like a tree that bends with the breeze. And so from that point of view, in regard to attitudes in regard to takeaways, in regard to attitudes to doctors visits and times of dosing, things like that, having sufficient regard to, you know, human needs to be flexible, but at the same time don’t put yourself in a position where you can be conned day in and day out. (Provider F)

Three respondents suggested that having clearly defined and well-understood systems for managing the various elements of their role enabled them to respond to clients with less prevarication and reduced the tendency for clients to seek exceptions to standard practice. As the following account shows, by having incorruptible service standards, providers reduce the likelihood of arguments with clients, which ultimately provides their relationship with a form of stability or security:

But also because you don’t know your clients, they’re more apt to test you harder. So now—they know me now. When I say no, it means no. In fact, they know not to ask. But in the early days they didn’t know me as well and the new clients that come in—you see, there’s such a network. They know within themselves that there’s a real
network. If I'd do something for one of them in the early days, then it would go right through. You know, if I gave someone an extra $3 credit, we'd have all of them asking for $3 credit extra, do you know what I mean. And we very quickly learnt that you don't do favours for one because if you're doing favours for one, you're doing favours for the whole lot, okay. So the lines are drawn in the sand [laughs] and you don't cross them. You know, you have to—you have to do that. And they're better off for it too. They don't get themselves into financial problems owing us lots of money. (Provider E)

Response 6: Commit words to action. All the providers discussed the importance of following up serious breaches of the treatment contract by clients and enforcing penalties laid out in it. Half the respondents suggested that having good systems of documentation and record-keeping assisted in the transparency, and therefore fairness, of this process. For example, giving clients written warnings not to persist with their behaviour and a reminder of the limited alternative treatment options available in a rural area was reported to be sufficient to provide an effective check on client behaviour in most cases. By establishing firm limits with clients and enforcing them, the respondents indicated that staff are not 'run ragged' unnecessarily or left feeling exploited and clients receive the message that the provider has confidence in their ability to cope with the negative consequences of their actions and not react impulsively. For many respondents, such as this one, balancing firmness with fairness was possible only after reflecting on the likely significance of the penalty for the client:

It's awful going home on a Friday with that sort of stuff onboard. And even though I am professional and I try and leave it, you do take a little bit of it home and you think, 'Oh, God, maybe I shouldn't have done that.' But deep down I know I'm not doing them any favours by being too lax, you know. Because they are in that position because people have been too lax around them, because they haven't had good, firm boundaries, you know; I don't know. But I think that we do need to keep our boundaries firm, yeah, and follow stuff through and not—I mean, I wouldn't be really hard and horrible, but, yeah, we need to follow through what we say, yeah. (Provider B)

Some providers stressed that enforcing sanctions was particularly important for new clients and those showing signs of instability. One respondent made the point in this way:

So that situation of beginning a relationship I think is very important. The other time that it becomes very important is when someone appears to be losing the plot a little bit. They appear to be intoxicated. Their behaviour becomes erratic. Those circumstances
require a firm hand to maintain control and to provide a level of stability for that person and to be sometimes directive and suggest that, you know, they’re not playing a game and they’re not doing the right thing by themselves and maybe they may need some alternate help. Refusing doses if appropriate, withholding takeaways, if appropriate. Issues like that is probably where you need to be firm. And obviously money is the root of all evil. I’ve found over the years in the early phases I had a particularly soft attitude to money because I recognised that the clients are often from a totally different socio-economic group than myself. And I probably created a rod for my own back by not chasing some debts when I should have...I’ve found over the years it’s the best inducement for someone to be reasonably current with their funds. Once they recognise that they’ve got to come in every day and they’re not used to coming in every day, that presents a cost and a burden in their own right, so it’s certainly worthwhile staying financially current. (Provider F)

Response 7: Find support in colleagues. All the respondents highlighted the positive impact of supportive collegial relationships on their ability to sustain therapeutic relationships with clients. In particular, the participants identified colleagues as an important source of advice and guidance, particularly when they were new to their position, and a means of assessing whether personal biases or prejudices were impacting on their work. The following account expresses the views of most respondents regarding the benefits of a strong team environment:

And that’s where team comes into play. And sort of if you’re feeling sort of frustrated or down about a situation, you just debrief with someone. It doesn’t make it go away, but you don’t have to deal with it alone. I mean, obviously we deal with things alone when we’re with a client as such, but, yeah, then when once the session is over, if we need to talk to someone, we do. (Provider A)

Response 8: Acquiring knowledge through experience of the role. All those interviewed reflected on the impact of learning about clients through their experience of engaging in a regular relationship with them over time. Many participants described their early experiences in this regard as a sense of being ‘thrown in the deep end’, where the only way to learn to deal with many issues was by encountering them. Acquiring knowledge about how to relate effectively to clients was described as a ‘personal journey’ that can take a lot of time and for which formal standardised training has its limits. The respondents indicated that the confidence gained from this kind of experience, however, noticeably reduced their stress over time; they were clear about their role and its limits and felt comfortable conveying this knowledge to clients.
Understanding their position was not seen to equate to accepting it or removing the need to make difficult decisions, but it was considered to make the management of the role easier. This view is shown in the following response:

But, you know, also I wasn’t used to dealing with people who had a drug habit, but now I am. And what’s more, rather than feel intimidated by somebody who’s got a drug habit—which we didn’t know in the first instance what they were like; you don’t—somebody else presents and you say, ‘Okay, well, are you really trying to help yourself or what?’ Whereas before you’d think, ‘Uh-oh, I wonder what this guy’s like?’, you know what I mean. Just a different attitude with experience you get. But you can’t learn that. You have to do it. (Provider E)

**Discussion**

The general purpose of the study reported in this chapter was to describe the opioid replacement treatment received by clients in the Southern Area Health Service, including the approach of key treatment staff to managing relationships with clients. The data acquired in the study serves as a baseline against which the client reports appearing in subsequent chapters can be assessed. A secondary aim of the study was to identify the main features of the therapeutic alliance formed between clients and a range of treatment staff in drug substitution therapy.

The assessment of the treatment parameters indicates that the SAHS Opioid Agonist Treatment Service, representing around six per cent of the New South Wales rural treatment population, is a very small program but one delivered over a substantial geographical area. Perhaps as an inevitable consequence of this combination of factors, it incorporates private sector features within its public sector framework. Moreover, the private sector elements of the treatment are localised according to the program’s three treatment districts. While the majority of program clients receive treatment in the community and contribute to the cost of their care through the payment of pharmacy dispensing fees, they tend to cluster in two districts containing small towns. Conversely, most clients who receive free dosing are clinic based and located in one city in the third district.
The distinction between clinic and community based clients that is forged in this way creates some significant consequences for the clients’ relationships with treatment providers that extend beyond any service constraints imposed by sheer geography alone. While service restrictions imposed by staff shortages mean that the program can be characterised as providing a basic level of intervention for all clients, the physical layout and service structure of the treatment for clinic clients results in their being much more supervised than community clients. The conditions placed upon daily dosing mean that they have much more frequent interactions with a wider variety of key service providers, including case managers, who assist with dispensing. With a lower provider to client ratio for dispensing and fewer restrictions on the time available for dosing at pharmacies, the intensity of engagement in the program is likely to be lower for community clients than clinic clients.

This does not equate to fewer pressures, however, particularly when geographical factors are taken into account. While they have less engagement with staff overall, restrictions in basic services and infrastructure associated with low population density mean that community clients in outlying areas have generally fewer treatment choices than their clinic counterparts. Not all small towns have hospitals, for example, and many have only one pharmacy that dispenses methadone or buprenorphine. As such, the successful management of client-provider relationships is potentially more stressful for both parties in remote areas where unstable or unemployed clients cannot readily access free daily hospital dosing or an alternative pharmacy.

Despite these differences in the structure of the treatment relationships for clinic and community clients, the program appears to have a reasonably stable workforce. While shortages of case workers have increased the staff to client ratio to almost double its expected level, the resultant ratio is comparable with, though at the upper end of, the staffing levels of large public clinics in metropolitan New South Wales (Bell et al., 1995). While case workers have opportunities for peer supervision and regular contact with prescribers, it appears that contact involving pharmacists is on an ad hoc basis. Given that pharmacists have the most frequent contact with community clients and no
formal training in handling the needs of the opioid dependent, they may experience the least amount of professional support of all service providers.

The professional profile of the small sample of SAHS providers interviewed about the management of client relationships is consistent with the profile of their peers described above. All providers were found to have had several years experience in their current role. While both case workers had caseloads of a similar size, there was a marked difference in the number of clients seen by each general practitioner and by each pharmacist. This was largely a result of the fact that one GP worked in two treatment districts while the other worked in one, and one pharmacist was located in a city while the other was based in a small town. Nonetheless, every participant in the two client studies was treated by at least one of the providers. In line with the practice of equivalent SAHS staff, the case workers and prescribers had regular peer contact, partly as a result of the requirements of their role, and pharmacists had contact with other providers only when they considered it necessary.

The analysis of the provider interviews indicates that the development and maintenance of a therapeutic alliance between drug treatment staff and clients in the SAHS is governed by inbuilt tensions, particularly at the beginning of a treatment relationship or when clients relapse. In accordance with the findings of Lilly and others (2000; 1999) discussed in Chapter 2, these tensions were found to partly exist at the level of the provider’s role. For example, all the providers identified a challenge in juggling the part of their position aimed at serving the needs of individual clients and the part of their position responsible for upholding public health regulations.

In addition, however, the results of this study indicate that tensions also operate at the psychological level of client-provider relationships. The task of treatment most frequently identified by providers, for instance, was determining the personal responsibility of each party in the relationship for achieving improvements in the client’s wellbeing. There is evidence to suggest that substance abuse treatment providers who acknowledge the client’s perspective and promote client autonomy in treatment produce higher levels of compliance and lower rates of relapse among clients
Client Satisfaction with Opioid Replacement Treatment

(Zeldman, Ryan & Fiscella, 2004). The finding is also consistent with much clinical evidence showing that the facilitation of client autonomy via the treatment relationship is an essential requirement of successful psychotherapy (Yalom, 1980). The providers in this study appear to use both direct and indirect means to address the issue. By advising clients of the consequences of their treatment choices and showing them how they become vulnerable to control, treatment staff seek to directly help clients acknowledge their contribution to their problems and to provide them with an experience of choosing their own actions in treatment. Indirect approaches to encouraging clients to assume responsibility for their treatment involve staff not operating outside the practical limits of their role or the limits of the role commonly defined by their peers and attending to the public health responsibilities of their position.

The second psychological dynamic in client-provider relationships in the SAHS opioid substitution program arises in negotiations over appropriate treatment goals. While all the providers appeared to be influenced by the tenets of harm minimisation in discussing client outcomes, half of them considered abstinence from all drug use, including the pharmacotherapy, as an appropriate treatment target for clients. These comments are sympathetic with the concept of ‘gradualism’ in substance use disorder treatment, where abstinence goals are incorporated into harm reduction models as part of the continuum of care (Kellogg, 2003). The dilemma for clinicians adopting ‘abstinence-eventually’ models, however, arises in determining the degree to which they nurture clients to achieve short-term improvements in wellbeing rather than promote to clients what they consider it is ultimately possible for them to achieve from treatment. The providers in this study appear to adopt an essentially responsive rather than directive position regarding individual client goals. Any personal disappointment resulting from discrepancies between their wishes for the client and the client’s achievements were reported to be ameliorated through their evolving understanding of the clinical presentation of clients struggling with addiction.

The final source of tension between SAHS providers and clients was found to be the development and management of the emotional bond between them. All the interview respondents described tensions or ruptures in their relationships with at least a
small segment of clients as an inevitability of the treatment process. They highlighted both passive attitudinal and active behavioural strategies for therapeutically managing these negative engagements. Passive approaches in such situations include containing emotional outbursts through patient and considered responses to clients, maintaining an open mind to treatment possibilities and being non-responsive to personal attacks. Such techniques would seem an effective response to client concerns regarding the need for treatment staff to be interested in, and patient with, their concerns (Bennett & Wright, 1986; Fountain et al., 2000; Gabbay et al., 1996; Lovejoy, Rosenblum, Majora, Foote, Handelsman & Stimmel, 1995). Active behavioural strategies employed by the service providers include following through on verbal commitments, demonstrating consistency in treatment practices and directly promoting client self-reliance. Team support and increased self-confidence in the treatment relationship acquired through experience of it over time were also identified as important factors in assuaging difficulties. There is partial support for these findings. Consistency in the delivery of treatment and respect for the time taken to establish therapeutic relationships have also been identified by clients as important ingredients in opioid replacement programs (Lilly et al., 2000; 1999).

In conclusion, the SAHS Opioid Agonist Treatment Service is a small, low intervention program serving both community and clinic based clients in a largely rural setting. It aims to stabilise and maintain clients on either methadone or buprenorphine and to do so increasingly through the use of the community sector. While there are notable differences in the structure of treatment received by community and clinic clients, both groups are served by a reasonably stable, experienced workforce. Prescribers are the only staff for whom formal training in treating opioid dependence is a compulsory condition of employment. However, case workers have regular opportunities for supervision and case review. By distinction, pharmacists receive no compulsory training for their role and little structured support. A small representative sample of SAHS service providers was found to have a largely client-centred approach to treatment influenced by the principles of harm minimisation. Tensions in the relationships between these providers and clients were reported to arise over issues of
client responsibility in treatment, abstinence from drug use and negative emotional states. These were found to be managed by a combination of active behavioural strategies, including direct discussion of the issues with clients, as well as more passive responses focused on the provider's personal attitudes as well as activities indirectly associated with clients.

The acceptability to clients of the program just described will be assessed in the next three chapters, which report on two studies examining the significant yet everyday treatment experiences of community and clinic based clients. The first of these studies, which is reported in the following chapter, is a preliminary investigation of client perspectives on treatment designed to test the validity of using resource exchange theory to conceptualise the process and content dimensions of treatment discussed in Chapter 3.
Chapter 6 – Using Resource Exchange Theory to Classify the Components of Opioid Replacement Therapy: A Pilot Study

The review of the satisfaction literature in Chapter 3 highlighted that client evaluations of health care usually include discrete judgments about the manner in which care is delivered by staff as well as the ingredients or results of that care, such as whether particular services were provided (Carr-Hill, 1992; Sitzia & Wood, 1997). As such, even in the most perfunctory, impersonal treatment encounters, the interpersonal process of engagement between clients and service providers is as potentially important to clients as the physical content of their care. Moreover, the quality of such interactions could be argued to underscore the attractiveness to clients of the treatment’s mechanical components.

Standardised measures of client satisfaction generally fail to differentiate between these process and content dimensions of care. This is also true of satisfaction instruments specifically developed for use in a substance abuse treatment environment, such as the Verona Service Satisfaction Scale (De los Cobos et al., 2002). The model of client satisfaction developed in Chapter 3 includes a classification system based on the principles of resource exchange theory aimed at preserving the salience of these components of care without pre-empting which aspects of them clients in opioid replacement therapy would nominate as significant. The general aim of the study reported in this chapter is to assess the usefulness of resource exchange theory in accounting for client evaluations of treatment in the Southern Area Health Service (SAHS) program based on these dimensions of care.

By treating satisfaction as the singular product of a client’s cumulative ratings of select aspects of a service, most instruments designed for assessing client satisfaction with opioid replacement therapy can shed little light on the degree to which clients value the interpersonal quality of the care they receive in contrast to the features of the pharmacotherapy itself—namely, access to the regular provision of an affordable opioid substitute in a safe environment. In the few studies where clients have been asked to nominate which aspects of their treatment they consider satisfactory or unsatisfactory
and to provide reasons for their choices, however, a different result emerges. In evaluations of substance abuse treatment programs for women, for example, clients have highlighted that improvement in treatment is specifically dependent on their being treated by staff who maintain a professional distance yet are capable of being caring and supportive, will not remind them of all their past mistakes and who take their feelings seriously (Conners & Franklin, 2000; Sanders et al., 1998). Others have reported avoiding treatment programs where clinicians such as general practitioners were experienced as unsympathetic and unresponsive to repeated requests for assistance (Fountain et al., 2000; Bennett & Wright, 1986). Research examining client perceptions of, and attitudes to, opioid replacement treatment also shows that clients are particularly vocal about service providers who are perceived to be condescending, ignorant and insincere (Fischer et al., 2002). Taken together, these findings suggest that clients consider the manner in which they are treated by staff to be as important to their retention and progress in treatment as the content of the treatment itself.

The above results also indicate that the impact of the interpersonal dimension of treatment is perceived at the level of the personal relationship between the individual client and each service provider. However, clients may also evaluate treatment delivery according to the staff’s response to their social identity as drug users and the stigma associated with stereotypes about membership of this social group. For example, in the evaluation of community methadone services in Victoria considered in Chapter 2, clients ascribed pharmacists’ tendency to serve other customers ahead of them to the belief that pharmacists regard methadone users per se as ‘scumbags’, ‘thieves’ and ‘junkies’ (Lintzeris et al., 1996). Given that individual clients may experience a positive personal relationship with a provider who is known to hold negative stereotypical attitudes towards clients as a group, for instance, it is important to have clear criteria upon which to assess the impact on clients of these different relational aspects of treatment.

The model of client satisfaction proposed in this thesis relies on principles of resource exchange theory to guide the classification of client experiences of treatment such as these (Foa & Foa, 1974; 1980). By describing six resources classes
underpinning interpersonal relationships and defining the rules for their transmission, the theory can account for the exchange of not only tangible goods and services but also abstract symbolic resources, such as compassion and respect, between the parties to a treatment encounter without presupposing their specific features. The circumplex ordering of the resource classes described in Chapter 3 shows how resources associated with the process aspects of treatment—namely, love, status and services—are defined by the nature of the relationship between the parties involved in their exchange. For example, love, which involves instances of affectionate regard, warmth or comfort, is the resource whose transmission is most highly dependent on the identity of the parties to the exchange and the quality of their relationship. As such, it encapsulates events impacting at the level of the personal relationship between a client and provider. Exchanges of status, which include judgments conveying high or low prestige, regard or esteem, are less particularistic and, arguably, more role based. Put another way, expressions of status arise in relationships involving more social distance, where their subjective value is less dependent on the history and nature of the relationship between the individuals involved and more on perceptions about the social group to which each party belongs. The exchange of services is similarly determined more by the social roles occupied by the provider and recipient than the quality of their personal association. Conversely, the more universalistic resources associated with the content of treatment—namely, information, goods and money—can be satisfactorily exchanged between people who have only a limited association.

This chapter reports on a pilot study aimed at evaluating the usefulness of classifying client evaluations of the SAHS treatment program according to these resource exchange theory principles. Three criteria were set to determine the merit of employing the proposed classification system. Firstly, in an unstructured data collection format, clients would be as likely to discuss issues relating to the processes of treatment as much as its content. In other words, themes regarding the interpersonal quality of client care would be nominated as significant in addition to themes involving the constituent elements of the treatment, such as the opioid substitute. Second, clients would discuss relational issues not just at the level of their personal association with
treatment providers but at the level of their social role as clients of the service. Third, the greatest number of resource classes could be used to categorise client treatment experiences. A secondary aim of the study was to identify interview probes regarding aspects of treatment that would be useful for the study of individual clients reported in Chapter 8.

**Method**

**Design**

While principally designed to test the proposed classification system, the study was also exploratory in nature because of its aim to generate probes for in-depth interviews based on participant insights. Focus groups were considered the most efficient data collection method for these purposes. The predominant advantage of a group environment is that it invites interaction amongst the participants which leads to relatively spontaneous responses and places the control of this interaction in the hands of the participants rather than the researcher (Morgan, 1988). The dynamic among members has the effect of focusing the group on the most important issues and highlighting extreme or false views. As such, it was considered that the participants would feel more comfortable sharing their feelings and opinions in a group setting than with the researcher alone.

In order to focus the collection of information in each session, facilitate a sense of cohesiveness and homogeneity amongst participants, it was considered that community based and clinic based clients would be interviewed separately. The sole eligibility criterion for participation in the groups was that the participants be current clients of the SAHS opioid replacement treatment program. Given that at the time of the study buprenorphine dosing had not yet been introduced into the clinic program and was only in its infancy in the community sector, it was anticipated that most participants would be receiving methadone treatment. Further, for the sake of practical expedience, only clients from the city of Queanbeyan, where the researcher was based, were recruited for the study. Being a pilot study designed to test the usefulness of theoretical ideas, the sampling restrictions imposed by treatment type and client location were not considered to limit the interpretability of the results. While maximum variation with
regard to client treatment history, drug use and age was sought, the threshold for participation on these grounds was necessarily flexible given that the total client population in Queanbeyan was relatively small \((n=80)\) and there was the potential for high non-attendance rates (Morgan 1988).

**Participants**

Twelve clients (nine clinic based and three community based) receiving methadone maintenance treatment were interviewed in three group sessions conducted between August and September 2002. Of these, one participant who arrived too late for a scheduled group session was interviewed individually because she was the only participant who was dispensed methadone at a small pharmacy containing only five clients and it was considered important to get the views of someone attending this pharmacy. The participants, three women and nine men, ranged in age from 22 to 51 years (mean = 36 years). Ten (83%) were unemployed. Heroin was the primary drug used by 10 participants, with the average length of opiate use being 15.5 years (range = 8-27 years). The average length of time in the Opioid Agonist Treatment Service was 4.3 years (range = 6 months-8 years), and the average length of time in opioid replacement treatment generally was 5.6 years (range = 6 months-10 years). The average number of treatment episodes (registrations on an opioid substitution program, including re-entry) was 2.3 (range = 1-5). Table 6.1 shows the final composition of each group according to the age and gender of the participants, their length of time in the SAHS program, length of time in methadone treatment generally, number of treatment episodes and whether they dose at the clinic or a community pharmacy.
Table 6.1  Clinical Profile of Focus Group Participants

<table>
<thead>
<tr>
<th>Group</th>
<th>ID</th>
<th>Gender</th>
<th>Age</th>
<th>Current Treatment Length</th>
<th>Total Treatment Length</th>
<th>Number of Treatment Registrations</th>
<th>Dosing Site</th>
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<tr>
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<td>A</td>
<td>F</td>
<td>22</td>
<td>6 mths</td>
<td>6 mths</td>
<td>1</td>
<td>Clinic</td>
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<td></td>
<td>B</td>
<td>M</td>
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<td>3 yrs</td>
<td>10 yrs</td>
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<tr>
<td></td>
<td>C</td>
<td>M</td>
<td>42</td>
<td>8 yrs</td>
<td>8 yrs</td>
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<tr>
<td></td>
<td>D</td>
<td>F</td>
<td>37</td>
<td>8 yrs</td>
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<td>E</td>
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<td>Clinic</td>
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<td>A</td>
<td>M</td>
<td>46</td>
<td>2 yrs</td>
<td>4 yrs</td>
<td>3</td>
<td>Clinic</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>M</td>
<td>32</td>
<td>1 yr</td>
<td>2 yrs</td>
<td>1</td>
<td>Clinic</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>M</td>
<td>28</td>
<td>6 yrs</td>
<td>6 yrs</td>
<td>5</td>
<td>Clinic</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>M</td>
<td>37</td>
<td>2 yrs</td>
<td>4 yrs</td>
<td>2</td>
<td>Clinic</td>
</tr>
<tr>
<td>3</td>
<td>A</td>
<td>M</td>
<td>26</td>
<td>2 yrs</td>
<td>2 yrs</td>
<td>1</td>
<td>Pharm A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>M</td>
<td>27</td>
<td>6 yrs</td>
<td>6 yrs</td>
<td>1</td>
<td>Pharm A</td>
</tr>
<tr>
<td>*</td>
<td>F</td>
<td></td>
<td>51</td>
<td>5 yrs</td>
<td>5 yrs</td>
<td>1</td>
<td>Pharm B</td>
</tr>
</tbody>
</table>

Note:  * = individual interview

Materials

In order to counterbalance the potential for chaotic information collection and to provide some comparability in the data generated across the groups, a questioning route comprising six open-ended questions was developed which aimed at illuminating client expectations and experiences of treatment. This is shown below at Table 6.2. The first two questions, which sought straightforward autobiographical information, were aimed at inviting participation from each group member and establishing a sense of ease and rapport among group members and the researcher. The next two questions sought to directly elicit the participants’ positive or negative evaluations of any aspect of their treatment. The remaining questions sought to identify issues which may be of significance in the treatment process for the client group generally but by which the group participants may not have been personally affected.
Table 6.2 Questioning Route for Focus Groups

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>All of you here have experience with methadone programs of one sort or another. How long have you been involved with this kind of treatment generally?</td>
</tr>
<tr>
<td>2.</td>
<td>How did you end up in this program?</td>
</tr>
<tr>
<td>3.</td>
<td>What has been helpful for you in coming here? Why?</td>
</tr>
<tr>
<td>4.</td>
<td>What would you like to change about the program? What would be more helpful? Why?</td>
</tr>
<tr>
<td>5.</td>
<td>If someone were about to get treatment for the first time and they entered this program, what do you think would be important for them to know? Why?</td>
</tr>
<tr>
<td>6.</td>
<td>Is there anything else you think is important that I should know?</td>
</tr>
</tbody>
</table>

Procedure

A variety of methods were employed to recruit clients into the study. Pamphlets advertising the purpose and location and contact number for the groups were distributed to clients from the clinic and both pharmacies by staff at these sites. Five participants were recruited through this method. The pamphlets were also included in a routine mailout reminder to clients regarding script renewals. Letters were also sent to both general practitioners (GPs) associated with the Monaro district to enlist their assistance in recruitment. Clients were also approached directly by the researcher when visiting the clinic for script renewals or counselling. Four participants were recruited by direct approach from the researcher in the clinic waiting room during dispensing hours. The remaining three participants, all community based clients, were recruited through introduction or telephone referral by a case worker at the centre.

All the sessions, which averaged approximately 60 minutes in length, were conducted in an upstairs meeting room at the Crossroads Clinic. The groups containing clinic based clients were arranged to coincide with the conclusion of the day’s dispensing in order to maximise attendance. The sessions with the community based clients were arranged at their convenience. In all sessions, the researcher, who acted as moderator, was assisted by another doctoral candidate from the ANU, who acted as notetaker. At the beginning of each session, information sheets outlining the purpose of the study were distributed to each participant along with consent forms for signing. The
participants were verbally reminded of the confidentiality and anonymity of their responses and the independence of their evaluations from their treatment at the centre. The sessions were digitally recorded on a laptop computer using Sound Forge XP 4.5 audio editing software (Sonic Foundry, 2000). While low levels of moderator involvement are important in exploratory research topics where the basic issues are not well known (Morgan, 1988), a higher level of involvement was required when interviewing community based clients than clinic based clients because of the small numbers involved. The greater degree of moderator input was not considered to bias the data collection towards consistency as it was mainly restricted to comparing the opinions of community clients with their clinic based counterparts. The participants were reimbursed $20 for their time at the conclusion of the group.

Each session was transcribed verbatim by the researcher as described in Chapter 5 and analysed using NUD*IST 4 (Qualitative Solutions and Research, 1997) qualitative data software. Data analysis involved the use of the inductive and deductive methods described in Chapter 5. As such, the rationale for their employment is not repeated here. The aim of the study was to describe the issues of importance to clients in the program from a resource exchange perspective. In particular, a confirmatory qualitative design was used to explore the usefulness of the concepts derived from that theory. The design needed to be flexible enough, however, to encompass the informants' understanding of issues they identified as important.

In line with the approach adopted in Chapter 5, the data analysis was conducted in two stages. In the first instance, inductive open coding was conducted, which resulted in the creation of a total of 782 concepts. These concepts were then grouped into 37 themes based on the similarity and frequency of the respondents' references to various aspects of their treatment experience, including treatment activities and relationships, as well as their personal history and functioning. Each of these themes and the concepts it describes is listed in Appendix C.

At the second stage, common themes were ordered into more abstract, core analytic categories that could account for the most variability in the data. Resource
exchange theory was used to organise the themes in two ways. First, because it is concerned with resources transacted within the context of an interpersonal relationship, all themes were sorted according to their applicability in the clients' relationship with one of three significant service providers: their case worker; their general practitioner; and their dispensing agent, be it the pharmacist or clinic dispensing staff. Second, each theme was then categorised according to one of the six resource classes involved in these relationships. The definitions adopted for assigning themes to these classes were based on those outlined by Foa and Foa (1980) and are included in Table 6.3. As expected, not all resource classes were exchanged in every relationship. This process highlighted the nature of the resources exchanged in each client-provider relationship.

Table 6.3  Definitions of the Resource Categories Used to Assign Descriptive Codes

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Love</td>
<td>Expressions of positive feelings of regard, warmth, affection, comfort, friendship and camaraderie</td>
</tr>
<tr>
<td>Status</td>
<td>Evaluative judgments conveying high or low prestige, regard, esteem or self-worth</td>
</tr>
<tr>
<td>Information</td>
<td>Advice, opinions, instruction or enlightenment. Excludes information that could be classed as an expression of love or status</td>
</tr>
<tr>
<td>Money</td>
<td>Any coin, currency or token that has some standard unit of exchange value</td>
</tr>
<tr>
<td>Goods</td>
<td>Tangible, products, objects or materials</td>
</tr>
<tr>
<td>Services</td>
<td>Activities that affect the body or belongings of a person. Often constitutes giving one's time, talent and energy for another</td>
</tr>
</tbody>
</table>


Of the 37 themes identified, 35 were categorised according to the various resource classes and service relationships and are displayed in a matrix in Appendix D. Two themes—namely, 'client time in ORT' and 'client time in SAHS'—contained only
quantitative information used for building the descriptive profiles of group participants and were dropped from further analysis. Themes grouped under a single resource category and provider relationship were reanalysed into a superordinate theme where the association between the central idea in each theme was conceptually coherent. Eight themes—namely, ‘addicts’, ‘work’, ‘being open’, ‘pharmacy takeaways’, ‘clinic takeaways’, ‘compare interstate’, ‘ORT reasons’ and ‘SAHS reasons’—could not be readily coded according to a relationship because they appeared to describe resources given and received by clients within the context of their admittance into the program structure. Upon reinspection, they appeared to highlight five resources gained and lost by clients simply through their agreeing to abide by the rules and regulations governing their participation in an opioid substitution program. From a theoretical perspective, these could be described as resource exchanges dictated by the nature of the institutional setting which form the basis of transactions among members who operate within it. Through its policy structure, the institution specifies the type of exchanges that will occur and what each party can reasonably expect to give and receive in return (Foa & Foa, 1974).

Four themes concerning case workers listed under the resource category of ‘love’—namely, ‘persistence’, ‘helpfulness’, ‘compare other NSW’ and ‘follow-up’—appeared to be better accounted for by a more abstract theme and were collapsed into a single item labelled ‘caring for the client’s welfare’. Five themes identified as services provided by the case worker—namely, ‘trust’, ‘case consultation’, ‘counselling’, ‘dosing time’ and ‘services’—were subsumed into a new theme labelled ‘consultation availability’. Five themes involving the GPs listed under the resource category of ‘services’—namely, ‘consultation’, ‘transfers’, ‘access’, ‘takeaway policy’ and ‘takeaway number’—were consolidated into more inclusive theme labelled ‘script provision’. Four themes related to the pharmacist under the resource of ‘status’—namely, ‘dose level’, ‘interest’, ‘trust’ and ‘status concerns’—were collapsed into a more general theme entitled ‘double standards’. A total of 15 themes emerged from this process.
Results

The findings are presented according to the resources clients perceive as being transacted, firstly, within the institutional parameters of methadone treatment and, secondly, within the context of their relationship with three significant service providers in their treatment—namely, their case worker, GP and dispenser, being either the pharmacist or the clinic dosing staff. As anticipated, not all resource categories were found to be significant in every relationship. Selected quotes from the participants are used to illustrate the significance of the resource category to either their treatment generally or the relationship with their service provider. In such instances, the participants are identified according to their group membership.

Institution

Love: Experiencing support. A theme raised by all three community based respondents was that engagement in methadone treatment afforded them the opportunity to restore or improve their capacity to experience and provide love and support in personal relationships. These clients indicated that participation in methadone treatment enabled them to sustain intimate relationships with life partners and children not directly involved in illicit drug use but who nonetheless had been adversely affected by its consequences. These participants reported that methadone treatment enabled them to divert personal resources usually invested in obtaining and using heroin, such as time, money and emotional energy, back to these close relationships. The consequence of this was not only increased reciprocation of support from loved ones but an increased awareness of the respondents' capacity to provide support with positive consequences, as the following account reveals:

3A: My best mate in hospital was nearly dead. And seeing the pain on [partner's] face, spending that much money—waste, just a waste. Since I stopped, we've got a unit, we've got blocks of land. Shit, that's only 2.5 to three years, sort of thing, so what can we do in 10? Shit, I don't work all the time. I only work part-time. If we could do that with me working part-time and her working full-time—that is my main aim, sort of thing—don't waste money on crack.
Status: Becoming a 'methadonian'. Eight participants reported that acceptance into methadone treatment was a public admission of their life as not only an illegal drug user but also as a user for whom such a life is no longer tenable. Such an acknowledgement of previously hidden, private drug use within the public health system was seen to expose clients to potentially negative discrimination from employers, other health care services and even out-of-treatment drug users. Many respondents spoke of the fear of being excluded from work or other health treatment opportunities because their public identity as a former heroin user invited authority figures to ascribe negative inferences about their personal character. In the case of authority figures, these would be based on perceived societal stereotypes about the personal qualities of illegal drug users—for example, that they are antisocial, untrustworthy and unreliable—that are unlikely to change or be redeemed. The following extract from a group of clinic clients portrays this point:

1B: I've got a sister-in-law. She is an enrolled nurse at the moment. She's doing the university course to become a registered nurse...She’s an ex-junkie type of thing. I think she’s off the methadone at the moment or on a very low dose. But her greatest fear is that they’ll find out in the work environment about her previous lifestyle, type of thing. She’s at the moment receiving distinctions and high distinctions, you know...I think if they knew about it in a work environment, they would push her out the door...I think that’s her biggest fear—that someone is going to ring up and put her in or whatever, you know.

1D: I never went on a methadone program for years because as soon as your name is down on that list—
1C: You’re registered.
1D: ...You walk into outpatients, they know that you’re up there on the drug and alcohol list. And so forget painkillers. I’ve had bursts where I wasn’t given a painkiller...
1B: And all they want to do is throw you a Panadol, you know. It’s because you’ve been an ex-junkie you’re suddenly immune to pain or you’ll never feel friggin’ pain again, you know. It’s absolutely ridiculous...
1A: ...They know they can give you more, but they won’t. It’s just like, ‘Take it or leave it’. Do you know what I mean?
1B: The leeway is there to give you whatever they think you need, type of thing. But you can see it in their eyes. It’s exactly the same thing again—you’re there to scam. You know?

The same point was made unanimously in another group:
2C: I've been unemployed since '99, and I finished up in a permanent job. I quit the job because the boss's missus worked at the maternity department in [the local] hospital. I was silly. I went there after work to pick up fits. I had my work uniform on. She told the boss straight away. I got shit work after that for up to six months. I just got sick of it and quit, you know.

2B: ...Most of them won't employ you if you're on the methadone. They think you're going to rob all their tools.

2D: Which usually happens anyway. Blokes do that.

2B: Yeah, it does happen. I admit I did it younger... I got busted. I went to jail for it and I done me time. But I've been paying for it ever since.

In addition to attracting broader social stereotypes, the respondents indicated that they were also subject to aspersions about their failure to maintain their chosen lifestyle as a heroin user. References to being 'bagged out' as a 'methadonian', usually by other illegal drug users, carried the inference that methadone clients couldn't make a life centred on heroin use alone 'work' for them and that they needed help. The respondents appeared to be less perturbed by this aspect of their status, however, as methadone treatment provided them with relief from the need to engage in criminal activity in order to finance drug use and an opportunity to experience the benefits of social and occupational activities conducted for purposes other than obtaining heroin. One participant described it this way:

2D: ... a lot of people turn around and say 'the methadonians' and shit like that. I don't give a stuff what other people reckon, you know what I mean. When I use it to make it work for me, it does me fine, you know what I mean. I don't care what they say because it does work for me when I make it. When I'm stable and in the right frame of mind, I'm right, you know what I mean. I can go to work and I can do what I want to do. So I don't really care what people say about it, bagging you and all that sort of shit.

Goods: Stopping the cravings. Perhaps not surprisingly, the single most significant resource which all the participants identified that they received upon entering treatment was the methadone itself. Many respondents referred to the 'stabilising' effects of methadone due to its ability to reduce or stop cravings for heroin and their consequent ability to lead a 'normal' life as a result of this. The following responses summarise the views of many respondents:

1D: ...Well, [methadone] makes you not have to go out and have a shot [of heroin] every day. So you don't have to get the money together.
And the fact that it’s here in the first place I think is the most helpful thing about it—the fact that it’s available at all. It definitely reduces crime. There’s no doubt about it—it stabilises people, you know. If you want to be stable on it, you can be. It’s your choice.

If you want it to work for you, it’ll work for you, no worries.

Yeah. You’ve got to want it to work for you, sort of thing.

Despite the common recognition of the pharmacological power of methadone in alleviating the problems associated with opiate dependency, there was significant variation amongst respondents in the degree to which they wished to harness this power. This was most clearly reflected in their goals for treatment. Clients dosing in the community endorsed personal treatment goals of abstinence from heroin use while the majority of clinic clients indicated that they aimed simply to gain better control of their heroin use through methadone maintenance. The following comments from one group of clinic clients expresses this idea:

But most people don’t come in here because they probably want to stop using [heroin].

No. Of course not. I don’t want to be sick.

It’s because of the hectic life you have to lead to be there, understand? It’s not because we hate the drug and what a shit it is. We all love it...We come here because out there is so hard...See, [the clinic staff] are missing the whole—we’re giving them the hint that we don’t want to stop, but they just don’t get that hint. I mean, whoever listens doesn’t hear that we don’t necessarily want to stop. It’s not that we don’t like it. We enjoy it.

We’re here because this is an easier option.

Conversely, the following view typified the approach of community clients:

There are two different sorts of people that are on the program—people who run two habits and people who want to get off all habits. Without saying who, there are people on the program here who want to use it as a free drug. It goes without saying. But there are people who it genuinely helps.

So your goal is really to become clean?

Yes.

Services: Clinic dosing times. A universal theme raised by all respondents yet voiced with particular vehemence by clinic clients was the restrictive nature of the once-daily, three-hour morning dosing times at the clinic. Several participants made comparisons with their experience of twice-daily dosing in interstate methadone
programs in discussing the issue. Community clients also highlighted its significance by indicating that freedom in dosing hours was one of the most important reasons driving their decision to obtain methadone at a pharmacy. Most respondents also considered that difficulty meeting casual manual work demands caused by the restrictive clinic dosing times was compounded by the removal of takeaway dispensing from the clinic and a policy requiring that clients commit to dose at the pharmacy for a minimum period of one fortnight. One participant described the problem in the following way:

1C: I feel here—before when we first started here we used to get takeaways and that on weekends. Then they stopped that, which was a real pain in the backside. You know, it was just stopped dead, you know. There was no say—yes or no you can’t. If you want a takeaway, you’ve got to go to the chemist for two weeks or transfer to the chemist fully, you know. There’s no leeway. Now the way the job market is, I’m picking up a casual day here, a casual day there. There’s just no leeway for it. I can’t get me dose. They don’t hold the doses. They won’t send the doses to the hospital. You’ve either just got to make it here before 10 to 10 or miss out on a day’s work. It’s ridiculous. For instance, last Wednesday I had a day’s work at Woolies doing stocktake. I started at six in the morning, had a 10-minute break at 9 o’clock. You know, I’m not going to lie to the boss, but I’m certainly not going to tell him that I’m coming up here to get me methadone, so I just left it at that.

Money: Cheap heroin alternative. Eight respondents referred to how methadone treatment provided them with relief from the financial pressures associated with satisfying their heroin dependence. All five clinic clients who raised this point considered it in the context of methadone being a cheaper alternative to using heroin while the remaining three community clients highlighted the benefits of having more money to spend on other personal goods and services, such as cars and property. One community client expressed the importance of this point in the following way:

4: And it’s amazing all the money I’ve saved too... So it’s real good. I love it—money in the bank. I can go and draw it out if I want to buy something. I love it. We bought a car for $8,000. Yeah.
Q: Better than chasing every day?
4: Yeah—buying rubbish, getting ripped off. You bet.

Case Worker

Love: Caring for the client’s welfare. Eleven participants expressed attitudes suggesting an expectation that case workers need to demonstrate care by showing an
interest in clients as individuals and being persistent in sustaining a relationship with them. While the most frequently reported manifestation of this expectation was case workers making telephone calls to clients following missed appointments or clinics, there was wide variation amongst participants on the degree to which they experienced this and why that was so. When speaking on this topic, several participants referred to case workers needing to ‘push a bit more’ or clients ‘going it alone’. Many indicated the importance of this kind of case worker engagement in either helping them to achieve their goals of abstinence from drugs or managing day-to-day problems involving housing, work or their emotional wellbeing. The following was a typical view of six participants:

1C: Even after you’re off it, there’s no follow-up. [The case worker] doesn’t bother ringing up and checking on you and seeing how you’re going and things like that. You know, my missus just got off it now and has been off it three months and not one phone call from here to say, ‘How are you going? Any problems arising from that?’ Junkies are the sort of people that don’t like opening up to other people. They’ve got to be forced to, you know, open up a bit. You’ve got to be pushed a little bit to get out how you’re feeling about it and, like, what goes on here… It’s as if you’re just here for them. If it wasn’t for us, they probably wouldn’t have a job…Sometimes that’s the way they look at it, you know. They don’t really give a hoot for anyone.

However, five participants in two other groups offered very different experiences of the same phenomenon. The following example is representative of their position:

2D: But there’s a lot of case workers that just don’t give a bugger, you know what I mean. But I think here being a smaller area, I think that’s why the case workers do. Whereas [a program in a large New South Wales city] was such a big clientele up there that they were probably snowed under with work…But down here there are less people. There’s more chance a case worker’s got to work with people. I got a phone call off a lady from here that was worried because I hadn’t shown up for two days…It sort of blew me out when the phone rang and it was her on the phone asking if I was all right because I’d missed for two days. It’s never happened before. So I think that was pretty good.

Status: Dealing with ‘junkies’. All participants expressed strong views indicating the importance of their case worker adopting an accepting, non-judgmental attitude to their background and handling of treatment. There were many references to the issue of ‘being looked down upon’, and how clients could ‘see it in their eyes’ when
they felt they were being negatively judged by their case worker. Most participants seemed to consider their treatment in the context of their self-identification as a ‘junkie’, a collective identity implying that they will be treated with suspicion and disavowal by people generally until they prove they should be treated otherwise. The following comments typify this point:

1E: Instead of making your life easier here, they seem to make it more difficult. They don’t want to help you. They look at it like you’ve done the wrong thing—‘It’s your problem’, you know.
1B: As though everyone’s on the scam... The moment you walk in, you’re a junkie. Everyone thinks you’ve got an angle, you’re working something to your advantage, you know. They can’t exactly say it. You can see it in their eyes.

The degree to which the participants believed that society generally, and their case worker in particular, treated them as a junkie and not as an individual deserving of respect seemed to vary according to the stage of development of the relationship. One respondent with five years experience in the program and comparatively frequent contact with a case worker described it this way:

4: No, the services here—I can’t complain about here. Very good people, nice people.
Q: Was that different from how you thought it might be?
4: I thought, ‘They’re [case workers] probably all bitches’ and all that. I thought they would think, ‘She’s a dirty little junkie’, or something like that. I did think like that, yeah, until I really got to know them a bit better. They’re all nice. I like them all. Not one of them I could say is a bitch. They’re all nice ladies.

Not all participants, however, relied upon the identity of being a junkie in determining how to interpret their case worker’s interactions with them. One respondent considered the issue this way:

3A: Although I’ve known other people who have all been amazed that I can go fishing [requiring a temporary interstate pharmacy transfer] so easily...It’s a thing I want to do at the spur of the moment. Other people have had problems getting to see relatives and stuff like that. But I know that other people have had problems here—yelled, screamed, carried on like idiots, abused the girls [case workers] and so forth. I’ve never done that. I’ve always been nice to the girls and the doctors. If you give respect, you get respect, I suppose. Yeah, they’ve been good.
**Information: Learning about the program.** The majority of participants indicated that their knowledge of how to derive the most benefit from their treatment was learnt through personal experience or association with others on the program rather than through discussion with their case worker. Learning personal rights and responsibilities on the program and how to interpret rules, such as for takeaways, were the most cited forms of knowledge learned in this way. In addition, several respondents indicated that they also gained significant information about social welfare issues and the clinical management of addictions from peers. Several participants indicated that they believed their case worker should be a source of guidance regarding these issues even though they needed to ‘work out [their] own solution’ for their treatment generally. The following are indicative of the views of respondents who indicated a desire for more information from their case worker:

1B: That’s how everyone learns what you can do and what you can’t do. I only learnt off other people around the place. No-one from the clinic ever filled me in on what was available or what I could access.

Q: So when you first entered the program, no-one sat down with you and said, ‘Well, this is what you can get?’

1B: No. ‘These are the facilities and when you get down the track this is what you can do, and you’ll be entitled to these takeaways or whatever’, no.

1A: *The case workers* give you a piece of paper—‘Read that’. That doesn’t explain it.

1C: They’ve got lists down in the waiting room of goals for the clinic and, you know, goals of treatment and your rights and responsibilities. But I don’t know how many people read them. They often get ripped down by the kids and that anyway.

1B: They’re fairly generalised anyway. It’s only a basic outline, type of thing. No specifics are given, type of thing.

Q: So if you had information, it would be helpful?

1A: Yeah. But no information is sort of given, sort of thing, until I spoke to—I changed to a doctor who actually listened to me and give me advice and said, ‘Just take it easy and do this.’

1B: Maybe some peer education group, a peer education night. And take all the new people and have a sit down and fill them in one night or something...At least you could regulate and make sure what they were getting was the correct information.

**Services: Consultation availability.** Ready access to their case worker for consultation or counselling was identified as being of importance to most participants. While only nine respondents reported having contacted their case worker for
counselling as part of their treatment, all acknowledged that they would feel comfortable discussing a range of personal issues, including financial, family and emotional problems, with them. The following response summarises this view:

3A: When there were deaths in the family, I was a bit upset and consulted [the case worker] about that. All sorts of worries, I suppose from money matters to family matters, I suppose, yeah. I feel I can speak to them about anything.

Q: So how did you go about arranging that?
3A: When nanna died, I just rang them up and said, ‘I need to talk.’ [The case worker] said, ‘Come straight in.’ That was easy.

The participants were divided over the degree to which they felt that they had been able to readily consult their case worker during times of stress. For example, some reported feeling dissatisfied with the need to make appointments if the matter involved some urgency. As two participants indicated:

1C: You know, you might have an issue that’s got to be dealt with then and there. Usually you have to make an appointment or something like that, you know. There’s just no flexibility here. Maybe it’s because the government has changed the rules. I don’t know, like I said.

1A: I have to wait until next week for an appointment and I want to speak to someone today about something. I’ve got to wait until next Tuesday. If [the case worker]’s busy on Tuesday, I’ve got to wait until the next after that. It’s just not going to help me now, sort of thing. I want to talk about it now. But what can I do? Just hang around? I’ll probably get depressed. That’s when people get in the mood of this temptation of having a shot or whatever, or just getting off your face. Do you know what I mean?

Several participants reported that they sought to facilitate contact with their case worker by coordinating the timing of appointments with other activities at the clinic, such as dosing times or script renewals with their GP. One participant expressed it this way:

1D: Well, I think it would be more easier if [the appropriate case workers] were here when we got dosed, do you know what I mean? Often I come down, I get dosed. Then I’ve got to come back at, say, 10.30. That’s two trips down here that I’ve made. I really don’t want to. I would rather make one. So I thought, ‘Next time, I’m going to make it at 10 o’clock. I’ll come down here at 10 to 10 on the end of [dosing hours] and I’ll just hang around for the 10 minutes and then I’ll go and see her. That’s what I’ve done because I’ve thought, ‘I’m not coming down here twice.’ ...I thought maybe if they made [appointments] within the dosing hours. I mean, they can’t be here at 7
o’clock, but say they come in at 8 or something, or 8.30 even. They would still have a good hour to get a few people in or maybe just one person a day. If they just did one person a day—just called them in very casually, you know. I think it could be casual. ‘Come in. You want to have a talk?’ Just an ask. That’s how I think it should be—just an ask. Not everybody has got a problem. Not everybody probably wants to talk.

On the other hand, several participants expressed views indicating that they were not necessarily hampered by the need to make appointments and could rely on their case worker to be immediately available and responsive in times of need:

2A: If you want to see your case worker, you just ask the people who are dosing and they’ll ring upstairs if they’re up there. You just walk around up the ramp and press the button and you can see them straightaway. You don’t have to make an appointment in two days time to see them.
Q: You don’t have to?
2A: No.
2B: Oh, you do usually. But if you need to see them quick, you can. Most of them will see you straightaway if you need to see them.
2A: Yeah. They will give you an appointment to come and see them. You’re supposed to, but as soon as you need to see them, you can just go straight up...If your case worker isn’t here, someone else will come down and try and help you, you know. Someone else will help you.

Prescriber

Love: Interest in the client’s wellbeing. All participants indicated that they consulted the clinic GP about their methadone treatment only and that they sought assistance with other health matters from an independent general practitioner. Despite this, seven respondents reported on the importance of having their methadone prescriber express an interest in their wellbeing that extended beyond simply their opioid dependence. When considering this topic, many clients referred to the ease with which they were able to discuss a wide range of personal issues with the clinic GP, including relationship problems, or share experiences of common hobbies. The following account reflects the views of six of the seven participants who reported having a trusting relationship with their GP:

2A: I’ve had strokes and things, you know. I go and see specialists. The doctor down here, he’s quite interested. He wants to see all the results. He wants to see all the results. He rings up my doctor here and talks to him and things, you know. That’s quite good.
2B: Yeah. They want to know what’s wrong and everything. They’ll ring up and check with your GP... [Doctor’s name] is the same doctor that runs the program I was on in [a town in New South Wales]. He’s the same doctor I’ve had basically for 10 years. I’ve sort of known him from town. He’s a GP in town. I went to high school with his daughters. He’s a good doctor. So I have been lucky that way with him. He still won’t give me an extra dose. He gives me none.

2D: He’ll talk it out with you. You and him sit down and have a one-on-one chat. You tell him how you feel. Mine does, anyhow—'How do you feel?' and shit like that. My doctor is also interested in how other things are going at home and all that sort of stuff, you know.

The participants identified their prescribing GP as the final arbiter of both access to the program and rewards once in the program, such as transfers to dose at the local pharmacy and scripts for takeaways, including from interstate chemists. Once access to the program has been granted, the provision of rewards by the GP is dependent on clients attending at clinic appointments, providing clean urine samples and regularly attending for dosing at the clinic. In discussing these issues, the respondents expressed the importance of being ‘judged on their own merits’ and having the GP show concern for them as individuals. For example, while almost all participants stressed the importance of having incentives to comply with program rules, there was variance in the degree to which they felt their compliance, or lack of it, had been recognised and responded to by their GP. One respondent reported being strengthened in her resolve to remain abstinent from heroin by the fact that her GP believed her reports enough to no longer ask urine samples from her and had encouraged her to ‘reward [her]self for her efforts. However, another participant appeared to associate her GP’s lack of admonishment of her for failing a urine test with indifference:

1C: Well, you have urines. They don’t penalise you. There’s no penalty. They don’t even drag you in and say, ‘Look, you shouldn’t be doing that. You’re on the ‘done, you know.’ They don’t do nothing.

1A: Like the doctor, he goes, ‘There was morphine found in your urine.’ I said, ‘Yes.’ I said, ‘I had a shot that day,’ I said, ‘because I was feeling depressed.’ And he goes, ‘Okay, fair enough.’ That was it. I just thought, ‘Gees, and the doctor didn’t even say nothing about it.’ It was as if he congratulated me, like, ‘Good on you’, you know.

1B: But I think that’s the way it has to be. There can’t be penalties there because people are going to fall off the wagon. We all do it. The moment they start penalising us and, you know, wanting you to jump off your dose, people just won’t attend. The methadone will be totally ineffective, you know.
Client Satisfaction with Opioid Replacement Treatment

Services: Script provision. Ten participants highlighted the importance of gaining ready access to their GP in order to obtain a script, particularly when first joining the program. Variance in waiting times to their first appointment ranged from two or three days up to well over a month and was comparable across both community and clinic clients. Most participants indicated that they could receive a script within a fortnight, which coincided with the timing of the GP’s attendance at the clinic. While all 10 respondents explained the waiting time to their first appointment with their GP as based on ‘luck’, the clinic and community clients differed markedly in the degree to which it was a problem. The accounts of clinic clients suggested a much greater degree of urgency about gaining access to a prescribing GP than those of community clients, reflecting their greater sense of need for treatment and expectation for receiving it quickly. The following reports from clinic clients summarises their perspective:

1B: You should be able to walk in, walk in the door and walk straight on to the ‘done…You should be able to see a doctor within 24 hours and be on the program. It’s absolutely ridiculous to ask a junkie to wait around for two weeks…What you’re meant to do for the intervening fortnight has got me. You know, like, everyone knows that they’re either going thieving or they do the best they can for the fortnight until they decide to come back. But the trouble is, given a fortnight away, which is half a lifetime to a junkie, they might be travelling quite comfortably in a fortnight so they’re no longer interested in coming in and getting on the ‘done. So that goes totally out of the back of their head until the next time we hit hard times and then we’ll come down and make another appointment and see how we’re going in a fortnight, you know.

2D: I was working all day just so I could have a shot to get to work the next day, do you know what I mean, for three or four weeks until I could get on the program.

2B: Yeah. It makes it hard. Not long ago, the doctor, he’s pretty old and that—there should be more stand-ins and that for him. He goes overseas and that. They have to bring another doctor all the way up from—

2D: [A town approximately 200km away].

2B: Yeah, that’s the one.

2D: I was even willing to go down there, you know what I mean? I was willing to go down there to sign me script so I could dose up. I went to the Methadone Complaints Board. I was on the phone to them every second day just telling them, following them up.

The following report, which is typical of those from the community clients, however, shows that the experience of waiting several weeks in order get a script is much less problematical:
3B: No, I didn’t have to wait a long time because there wasn’t that many people back then. No, probably—I think it was about three weeks, I think. I went and got me thing at the doctor and it was two or three days after that I got dosed...I more or less got straight on it.

Goods: Dose level. Eleven participants described the importance of finding the level of methadone dose that would be necessary to prevent cravings and produce ‘stability’ yet sufficient to minimise adverse side effects of the drug, such as drowsiness. While the respondents acknowledged that the decision to increase or decrease their dose was theirs, all stated that achieving a dose level that would adequately meet their needs required at least several months commitment to treatment, particularly as the rate of increase or decrease was set by their GP. Most participants appeared to accept the long-term nature of treatment because of this and were prepared to be guided by their doctor’s advice. The following response was typical of most respondents’ approach to the issue, wherein they attempt to balance their GP’s desire to alter dose levels at the regulated or standard rate with their understanding of personal tolerance to varying drug levels achieved through many years of drug use:

2B: ...If you go down and you want to go up, you can go back up to your previous dose provided it’s only half a mil or something. There’s not much point. Yeah, they’ll whack you up pretty quick but they don’t like bringing you down too quick. I’ve always come down half a mil a week and they say, ‘That’s too fast, that’s too fast.’

2D: When I got out of jail, I thought, ‘I’ll do it my way.’ This sheila [a general practitioner], she was an old lady, right...I thought this old sheila wouldn’t have had any idea. But she did. She knew what was best. She said, ‘[2D], don’t come down any quicker than that’, because she was sick of bringing people down too quick and it wasn’t working and you have to put them back up, you know. So the way she brought me down worked for me, do you know what I mean?

Pharmacist

Status: Double standards. While nine of the 12 participants received their methadone from the clinic, all reported personal experiences of obtaining their dose from at least one of the local pharmacies at some point in their treatment history. Nine clients described the pharmacist’s approach to methadone clients as a group as ‘hard-hearted’, ‘cheeky’ and ‘moody'. This manifested in their being ‘discriminated against’ by being served last, followed closely by chemist staff on suspicion of theft and
receiving ad hoc numbers of takeaway doses. The respondents who despite the pharmacist’s ‘double standards’ persisted in obtaining their dose from pharmacies in the longer term—that is, community based clients—did so because of the benefits of flexible dosing times and the provision of takeaways afforded by pharmacy dosing. However, this required the acceptance of an ongoing ‘unstable’ relationship. One client provided the following example of his experience:

3B: Like, it could be your day to get a takeaway, but if you go down there and [the pharmacist’s] in a bad mood, you don’t get it.
Q: Really?
3B: Yeah. I’ve had him tell my partner, ‘No, we don’t have the methadone here. We might not get it until tomorrow.’ She has rung [the clinic] and they’ve rung [the pharmacist] and said, more or less, ‘Well, when are you going to get it?’ Sort of lunchtime she got her takeaways... It just depends what sort of mood he’s in.

Q: And you’ve talked to [the pharmacist] about it?
3B: Oh, I’ve had screaming matches about it, about double standards and just not putting up with his bullshit.
Q: So you end up screaming about it?
3B: Oh, they’re not happy about you swearing at them. But just whatever you say to them, it goes over their head, sort of thing.
Q: What happens then?
3B: I mean, he just told me, ‘Pull up or I’ll send you back [to the clinic].’

Not all clients, however, described their relationship with their pharmacist in negative terms. One participant described an association based on trust and encouragement:

4A: My chemist, he’s really good too. He [drops the dose level] without me knowing, you know what I mean. I told him to—to drop me down every month so I don’t know, do you know what I mean? I’m going to work it where I can get that tablet [buprenorphine], do you know what I mean? Get on the tablet.

Q: It sounds like there’s a bit of trust there with your pharmacist?
4A: Yeah, he’s pretty good...They reckon that the other man up there is a pig at the [other] chemist, but I don’t know. They reckon he’s real rude. Well, [my pharmacist] is not. As soon as he sees me coming in the door, he gets me dose ready, do you know what I mean? He’s real good.

Money: Treatment costs. Eleven participants reported that the $5 upfront cost of a methadone dose at the local pharmacies was expensive, particularly in comparison with a range of interstate pharmacies, which charged between $2 and $3.60.
Most attributed this increased cost to the ‘greed’ of the pharmacist who could ‘charge [clients] $1 a day’ and ‘still make a good profit’. Some clients indicated providing regular clients with a discount would be a good incentive for continuing to dose at the chemist on a long-term basis. All pharmacy dosing clients reported the importance of maintaining their accounts up to date in order not to be transferred back to the clinic. This was shown in the following comment:

3B: For ages, since I went down there, like, I was getting, like, a fortnight behind. And I would pay on me payday. And then they would let me go until the next fortnight, which would be $70. But probably a month ago they handed out a letter saying that if you got $35 behind you wouldn’t get your takeaways, and if you got $70 behind you wouldn’t get dosed and you’d get sent back up here. So we try to get ahead with our payments. Since then, I think one of the pharmacists down there said that five or six people have come back up here [the clinic] since they done that.

Clinic Dispensing Staff

Services: Adherence to dosing times. Despite the strictures of program policy regarding clinic dosing times, five clinic participants indicated that dosing times were enforced in an arbitrary manner, with different rules for staff and clients. The following account highlights this point:

1D: And we only have three hours in which to pick up our dose. I mean, I missed out by 10 minutes the other day and I just had to walk away. There’s nothing you can do. You can bang around, jump up and down.
1E: Yeah, that’s another thing too. I’ve been here in the morning and the staff forget to open the place or one hasn’t turned up. They’ll be an hour late or something. If you’re two minutes late out the front here waiting and they walk out, they just won’t give you your dose...And like what happened to [partner] the other day—two minutes late or something. It’s not like she does that every day; it happens once in a blue moon. Knowing she has two kids to take care of, they just didn’t care. They said, ‘Well, you go, instead of taking two minutes of my time.’

The respondents appeared to diverge in their reasoning for the perceived discrepancy in rules for clients and staff regarding the issue of punctuality:

1B: But I think that’s where it comes back to you’ll get people who will come down and do that...four times a week—be late and want their dose, you know. It’s just the hard-hearted attitude that everyone gets—‘Oh, fuck it. If I do it for her, I’ll have them
all down here fucking wanting it, you know. It just goes along with the attitude, you know—fucking junkies.

1C: I can see a positive—that may be they’re trying to get us to live a structured—to structure our life a bit better, you know. Maybe they are, you know. You’ve got to be here at a certain time and you’ve got to be there. There’s negative and positives to it, you know.

Discussion

The overall purpose of the study reported in this chapter was to examine the feasibility of using resource exchange theory to classify the process and content dimensions of treatment. The viability of using this theoretical approach rested on clients nominating aspects of their relationship with treatment staff as significant in addition to the defining ingredients of the treatment itself, such as the opioid replacement. Further, it was important that clients identify relational issues not just at the level of their individual personal association with providers but at the broader level of their treatment group. Finally, resource exchange theory was considered to be useful when events representing the greatest number of resource categories would be identified by clients as significant. The secondary aim of the chapter was to identify client experiences in treatment that could serve as probes in the individual interviews with clients that are the focus of Chapter 8.

Over 80 per cent of the clients interviewed in this study had been enrolled for over a year in the SAHS program and had spent more than two years in opioid replacement treatment prior to their current registration. As such, most had had experience with the different rules applying to the community and clinic dosing arms of the SAHS service and with the rules of other treatment programs to inform their evaluations.

Like previous research on client attitudes to opioid replacement therapy generally (Mavis, DeVoss & Stoffelmayr, 1991; Neale, 1998), this study found that clients derive several benefits from the institution of maintenance opioid treatment simply due to its availability. More specifically, the clients in this study, like others (Fischer, Chin, Kuo, Kirst & Vlahov, 2002; Neale, 1998), identified a reduction in their illicit drug use, drug-related harm and reliance on crime as significant benefits resulting
simply from their commencement of the treatment. The pharmacological efficacy of methadone in stopping heroin cravings was universally nominated as a major benefit underlying their decision to enter the program. In addition to the content of the treatment, the clients in this study reported changes in their personal relationships as a result of entering the program. While enrolment on the program provided them with an opportunity to improve relationships in their private life, the respondents reported mixed views on their inevitable adoption of a public role as a methadone client and the program’s approach to enforcing rules. Their response to service delivery rules accords with findings in previous research, where clients have been divided about whether the rules of engagement for various aspects of treatment, such as dosing times and locations, are appropriate and applied too strictly and punitively (Fischer et al., 2002; Neale, 1999).

While these results indicate that a range of different resources are acquired by clients upon their entry into the institution of treatment, resources exchanged in their relationships with service providers were found to figure more prominently in reports of their treatment experiences. Ten of 15 themes arising from the focus groups concerned issues with providers. In particular, clients had the most to say about their relationships with their pharmacist, clinic dosing staff and case worker. Issues with GPs were more limited in scope and arose less often. Given that clients have far fewer exchanges and exchanges of a more circumscribed nature with prescribers than other providers, this result was not surprising.

Exchanges involving the particularistic resources of love, status and services appeared to dominate client discussions regarding case workers. These resources were defined by client reports about the importance of being cared for, not being negatively stereotyped by and having ready access to their case worker. In theoretical terms, these are resources that are usually identified only once a relationship has attained some stability or reached a certain stage of development (Foa & Foa, 1974). In other words, they are not likely to take on significance in incidental or instrumental associations. Given the central role of case managers in coordinating client care and providing
support services, this relationship involves the most regular exchanges of a meaningful nature in a client’s treatment. Consequently, these results are not unexpected.

The findings indicate that clinic clients have more opportunity for engagement with their case worker than community clients. Accordingly, they had most to say about this relationship. However, the clinic clients varied widely in degree to which it was regarded as positive or negative. This appeared to be based on perceptions regarding the amount and availability of contact they had with their case worker. Those who reported receiving follow-up contact, acceptance and prompt assistance from their case worker described the relationship in positive terms. Because resources of love, status and services such as these emanate from the process of interpersonal engagement, their value cannot be preserved for long without ongoing regular contact. Given that community clients, who have low levels of contact with their case worker, did not describe their relationship with their case worker in negative terms, it is possible that the differences between the clinic groups may be due to variation in their needs for, and expectations of, receiving care.

A similar pattern of results was found for client experiences with prescribers. Particularistic resources of love and services predominated in client reports of this relationship. These took the form of themes regarding the clients’ need for their GP to take an interest in them and to be reliably available to grant access to the program. Once again, clinic and community clients differed in their views, with some clinic clients indicating that their GP expressed little interest in them as individuals and that they had to wait an unacceptable length of time to gain entry into the program.

Respondent reports indicated that client relationships with the pharmacist involved predominantly negative exchanges of the universalistic resource of money and the particularistic resource of status, at least for one pharmacist. In particular, this translated to concerns about the expense of treatment and clients receiving a lower level of service than other customers of the pharmacy. This latter finding is consistent with the published experiences of other clients treated in the community sector, where staff have been described as patronising, ignorant, disingenuous and uninterested in illicit
drug users (Bennett & Wright, 1986; Fischer et al., 2002; Fountain et al., 2000; Gabbay et al., 1996). Clinic clients also reported negative exchanges with dispensing staff over the issue of inconsistency in service delivery.

The study has two main limitations that need to be taken into account in considering these findings. First, an obvious difficulty with ascribing one resource category as a totalising descriptor of client experiences with an aspect of treatment is that several resource classes may be involved in a single exchange between a client and provider. Client concerns regarding the cost of dispensing fees, for example, may reflect an issue regarding the resource of money. However, if clients report they have to pay more for treatment than other pharmacy customers because the pharmacist dislikes methadone clients, the resource of status is also implicated. Determining which resource class predominates in an exchange is an act of interpretation for which clear classification criteria need to be established and coding reliability measures employed. The second main limitation of the study is that the members of each group tended to express homogenous views. The first group of clinic clients was generally negative in considering most topics while the second group was generally positive, as were the community clients. The degree to which differences in opinion reflect differences in individual needs and expectations therefore needs to be tempered against the propensity for the data gathering method to produce responses skewed to a group norm.

In conclusion, this study has found that SAHS clients appear to be as concerned with the way treatment is delivered by staff as much as with the components of the treatment itself. Moreover, all six resource classes were able to be employed in accounting for the aspects of treatment that clients identified as significant. In particular, resource exchange theory was useful in discriminating between issues nominated by clients as existing at the level of their personal relationship with staff as well as at the level of their group membership. While they can be considered only tentative because of weaknesses in the data collection method, the results of the study suggest that client experiences of treatment vary widely. Interviews with individual clients would be the most appropriate means by which to seek confirmation of these results. As such, it is the approach adopted in the study reported in Chapter 8. To the
extent the differences in treatment experience may be associated with differences in the profiles of clinic and community clients, this is addressed in the following chapter.
Chapter 7 – Client Satisfaction with Opioid Replacement Treatment in the Southern Area Health Service: Profile of Respondents

The model of client satisfaction proposed in this thesis posits that the expectations underscoring client evaluations of treatment are likely to relate to the individual circumstances of the client as well as the features of the program in which he or she receives care. This is in line with the ideas proposed by Thompson and Sunol (1995), who argued that three types of factors influence the development of client expectations—namely, the aspects of the treatment environment that render it unique; personal factors related to the needs, values, roles and treatment intentions of the client; and social factors represented by the client’s socio-demographic status. Where Chapter 5 described the features of the Southern Area Health Service (SAHS) treatment program that influence the development of client expectations, the general aim of the current chapter is to describe clients’ personal and social profile as it impacts on their expectations for care. In a substance abuse treatment context, clients’ demographic background, drug use and treatment history, reaction to the treatment environment and physical, social and psychological health will be relevant factors in the construction of such a profile. In line with the suggested model of client satisfaction, clients with greater psychosocial needs in these domains could be expected to have less tolerance for unmet expectations and, therefore, potentially greater dissatisfaction with opioid replacement treatment.

In accordance with Australian government policy, the public clinic in the Opioid Agonist Treatment Service of the SAHS assesses treatment applicants, provides services for clients with more complex needs and transfers stable clients to community providers. In functional terms, stable clients are defined as those who remain regularly and reliably in contact with treatment providers, do not present intoxicated for dosing, show appropriate social behaviour and adhere to treatment rules (New South Wales Health Department, 1999). The transfer of stable clients from the clinic to the community suggests that there will be some differences between them in their level of personal and social functioning. In general, clinic clients could be expected to have fewer psychosocial resources, less experience with treatment and poorer reactions to the
treatment climate than their community based peers. A secondary aim of the current chapter is therefore to examine whether there are reliable differences between these clinic groups which would lend support to the current transfer policy.

A range of personal characteristics and preferences are associated with clients' attraction to, retention in and improvement during opioid replacement treatment. With regard to demographic factors, the increased availability of methadone maintenance treatment, either as an alternative to other treatments or through expanded scope, has resulted in older clients being attracted to, and retained in, treatment over time (Brands et al., 2002; Eland-Goossensen, van de Goor, Benschop & Garretsen, 1998; Eland-Goossensen, van de Goor & Garretsen, 1998; McLellan, 1983). Over the last 30 years, for example, the average age of clients in Australian samples has risen from the early twenties to the early thirties (Reynolds, 1975, cited in Caplehorn & Batey, 1992; Mattick et al., 2004). The gender ratio of program clients is usually weighted in favour of males, and this is the case in New South Wales and Victoria according to the most recent available estimates (Lintzeris et al., 1996; Public Health Division, 2004). Lastly, significant proportions of clients in Australian opioid replacement treatment programs are likely to have finished their formal education at 15; to be unemployed or in receipt of some kind of welfare; and to have a criminal record (Bell et al., 1995; Byrne & Wodak, 1996; Lintzeris et al., 1996; Ward, 1995).

In terms of the drug use patterns of program clients, most applicants to opiate replacement therapy have been found to be dependent on not just opiates but a range of other substances. Multiple drug use during treatment is often associated with poorer retention, a higher incidence of risky behaviours, such as needle sharing, and lower social functioning (McLellan, 1983). In Australia, benzodiazepine use has been associated with the opioid dependent both in and out of treatment (Darke, 1994; Darke, Ross, Teesson & Lynskey, 2003; Darke, Swift & Hall, 1994). Alcohol abuse has also been associated with opioid users (Khantzian & Treece, 1985) and found to negatively impact on their retention in treatment (Torrens, Castillo & Perez-Sola, 1996). In addition to using other drugs, clients with longstanding and severe levels of opioid
dependence have also been described as less likely to persist with treatment (Ball & Ross, 1991).

When compared with rates in the general population, clients in opioid replacement therapy have markedly elevated levels of physical and psychological health problems (Millson et al., 2004). Indeed, the expansion of treatment programs in many parts of the world in the 1980s, including Australia, occurred in response to the discovery of almost epidemic levels of HIV infection among injecting drug users (Joseph, Stancliff & Langrod, 2000). Opioid users also report high levels of hepatitis B and C, which often develop as a result of their sharing injecting equipment (Darke, Hall & Carless, 1990). Psychological distress, revealed through affective as well as personality disorders, is also prevalent among clients of opioid treatment programs. While the direction of influence in the relationship between psychological dysfunction and opioid dependence is unclear, there is evidence that some disorders abate for those who spend longer in treatment (Calsyn, Wells, Fleming & Saxon, 2000). Nonetheless, studies using quantitative measures of psychopathology have identified depression and anxiety as the most common affective disorders and antisocial personality disorder, borderline personality disorder and narcissistic personality disorder as the most common characterological problems besetting those in opioid replacement treatment (Ball, Nich, Rounsaville, Eagan & Carroll, 2004; Cohen, Gertmenian-King, Kunik, Weaver, London & Galynker, 2005). The prevalence of disorders among clients in treatment has ranged from 16 to 30 per cent for affective disorders such as depression (Teesson, Havard, Fairbairn, Ross, Lysnskey & Darke, 2005), from 36 to 60 per cent for the antisocial and narcissistic personality disorders (Ball et al., 2004) and 45 per cent for borderline personality disorder (Darke, Ross, Williamson & Teesson, 2005).

A considerable number of clients of opioid replacement programs continue to receive social support from drug using associates once treatment has commenced. While continued associations with such peers may provide forms of emotional support in times of difficulty, they may often result in poorer treatment outcomes for clients. Those who maintain social links with active drug users, particularly those living with substance using intimate partners (Gogineni, Stein & Friedmann, 2001), have been
found to be more likely to participate in illicit drug use during treatment (Schroeder, Latkin, Hoover, Curry, Knowlton & Celetano, 2001). Client involvement with drug using peers is also influenced by the physical layout of the treatment site. Those who associate with treatment environments that they consider minimise opportunities for illicit drug consumption and maximise client safety and privacy tend to have greater success in achieving and maintaining abstinence from drug use (Grosenick & Hatmaker, 2000).

The foregoing examination indicates that a range of characteristics shape client responses to opioid substitution therapy. As a minimum, therefore, the comparison of the profiles of clinic and community based clients in the SAHS will be built on a description of their demographic characteristics, treatment history, drug use history, physical, psychological and social functioning and overall reaction to the treatment environment. In particular, it is anticipated that clinic clients would have less experience in treatment, greater levels of concurrent illicit drug use, poorer social, physical and psychological functioning and more negative reactions to the treatment environment. This would reflect a greater need for personal resources and, as such, a lower level of tolerance for unmet expectations in their evaluations of treatment, which are reported in Chapter 8.

Method

Design

The data considered in this chapter are an adjunct to a larger pool of cross-sectional interview data collected in the study of client experiences of treatment reported in the following chapter. A structured questionnaire was deemed the most appropriate and efficient data collection method for developing a profile of the interview participants for three reasons. First, for logistical purposes, individual clients in all three treatment districts of the program could be interviewed feasibly only once and client experiences of treatment were the main focus of interest in the available time. Second, the information required was largely factual in nature and did not require clients to express their feelings or opinions. Third, a questionnaire format would produce regular and
uniform data that would enable systematic comparisons between the two main client groups.

The selection of clinic and community clients for participation was based on a variety of sampling strategies. In the first instance, a geographically stratified sample of potential participants was targeted from the Monaro, Coastal and Northern treatment districts. Following this, maximum diversity in the variables of gender, age, length of time on the SAHS program and length of experience in opioid replacement therapy underpinned the selection of community and clinic based participants in each of these areas. This allowed the theoretical concepts to be examined according to the greatest number of client and treatment conditions. Finally, where response rates were low, particularly in less populated areas, snowball or chain-sampling strategies were employed. This involved participants nominating other clients who would be likely to provide information of relevance to the study. Four clients were recruited through this latter method.

Participants

Fifty-five clients (30 clinic based and 25 community based) were recruited for interview between May 2003 and March 2004. Of these, 37 (30 clinic based and seven community based) were from the Monaro district; 13 were from the Coastal district; and five were from the Northern district. Based on the client numbers in each treatment district in June 2002, this represented 36 per cent of clients in the Monaro district, 26 per cent of clients in the Coastal district and 10 per cent of clients in the Northern district. The average age of the sample was 35 (median = 35 years; range = 21-54 years), which is slightly older than the average age of 33 reported in descriptions of recent Australian samples (Mattick et al., 2004). Fifty-eight per cent of the sample was male, which is comparable with the gender breakdown for clients of rural programs in New South Wales in 2003 (Public Health Division, 2004). Seven per cent of the respondents identified themselves as being of Aboriginal descent and 91 per cent identified their birthplace as Australia.
Materials

The questionnaire used to create a profile of the respondents was developed by the researcher and is contained at Appendix E. Where possible, standardised instruments with established reliability and validity were employed. The questionnaire contained four sections seeking quantitative information about clients' demographic characteristics and treatment status, including their perceptions regarding the need for particular resources; current and recent drug use; health status, including their physical, psychological and social functioning; and global assessment of the quality of the program.

Questions regarding clients' demographic details and treatment status (section A of Appendix E) were based on the format used in the yearly surveys of injecting drug users undertaken by the Illicit Drug Reporting System (IDRS), which is a national illicit drug monitoring system aimed at detecting emerging trends in illicit drug use in Australia (National Drug and Alcohol Research Centre, 2000). More specifically, questions regarding clients' demographic details included their age, educational history and current relationship and employment status. Questions concerning their treatment status were based on their length of experience with different types of treatment for opioid dependence, including in the SAHS program; details of their current treatment structure, including methadone or buprenorphine dose level and amount of contact with SAHS staff; and expectations for completing the program. An additional question (A23 in Appendix A) was developed to establish clients' perceived need for each of the six resource types as they manifest in opioid replacement treatment generally. Its format was based on the Inventory of Wishes for Interpersonal Resources, an instrument derived from resource exchange theory principles that measures the strength of desire of individuals to receive more of a given class of resources (Foa & Bosman, 1979). Using a five-point scale, clients are required to rate the degree of importance of six generic items representing each of the six resource classes in the institution of opioid replacement treatment. Higher scores indicate a greater need for that resource type.
The second section of the questionnaire (section B of Appendix E) contained a series of questions about each client's current, recent and long-term history of drug use. Questions about current use aimed to identify what drug clients considered their main problem and how serious the problem was. Questions about recent drug use history aimed to categorise the frequency of use of a range of drugs in the month immediately preceding the interview as well as the total amount and regularity of their use on the last day of consumption. Finally, questions about clients' long-term drug history aimed to identify the type of drug first used and the age at which it was introduced.

Questions seeking to quantify clients' physical health problems, including injection related problems (section C of Appendix E), were based on similar questions in the injecting drug users survey of the IDRS. The Millon Clinical Multiaxial Inventory (MCMI-III) (Millon, Davis & Millon, 1997) was used to measure clients' psychological health. The MCMI is a 175-item inventory measuring the presence of 14 personality disorders and 10 clinical syndromes, including drug and alcohol dependence, in clinical populations. These correspond closely to most of the Axis I and Axis II categories of the international diagnostic system found in the fourth edition of the Diagnostic and statistical manual of mental disorders (DSM-IV) (American Psychiatric Association, 1994). The normative sample for the MCMI consists of 998 men and women representing a wide variety of diagnoses and includes patients seen in independent practices, clinics, mental health centres, residential settings and hospitals. It is one of the most popular measures for assessing psychopathology in substance abuse populations (Ball et al., 2004). The instrument also includes a validity indicator as well as three indices of response styles known to modify result profiles. Responses are rated as either true or false. Base rate (BR) scores above 75 indicate the presence of clinically significant traits while scores above 85 indicate the presence of a disorder.

Clients' social functioning was measured using the social functioning scale of the Opiate Treatment Index, which has been found to have reasonable validity and reliability (Darke, Hall, Wodak, Heather & Ward, 1992). The social functioning scale assesses a client's level of social support, degree of conflict in personal relationships, extent of involvement in drug using networks, occupational and residential stability and
number of personal crises in the last month. Higher scores indicate higher levels of dysfunction.

A quantitative measure of client’s global perception of the quality of the treatment environment was obtained with the widely used Client Satisfaction Questionnaire (CSQ-18B) (Larsen, Attkisson, Hargreaves & Nguyen, 1979). It is shown at section D of Appendix E. The CSQ-18B is an 18-item measure designed to assess clients’ satisfaction with health services, including the amount of help received, the quality and competence of staff, the general quality of the service and the adequacy of the physical treatment environment. All items are summed to produce a single index of satisfaction, with higher scores indicating a greater level of satisfaction.

Procedure

Letters and pamphlets outlining the details of the interviews were sent to clients either directly or through case workers via script renewal reminders. Clients in the Monaro district were also approached directly during dosing hours at the Crossroads Clinic or outside the two pharmacies in Queanbeyan at times when clients were known to collect doses. Nine pharmacists in six towns with the largest number of clients were approached to distribute pamphlets advertising the interviews. One declined on the basis that the pharmacy had a history of unsettled client behaviour and it was feared that asking clients about their experiences on the program would destabilise the newfound order achieved in working with the clientele.

The interviews were conducted in a room at the Crossroads Clinic or at the home of the client. Where home interviews were conducted, the researcher was accompanied by an assistant for security purposes. Once initial rapport had been established with the respondent, however, the presence of the assistant was not considered to impede the quality of information provided. Seven couples on the program were interviewed together because of time constraints, which arose primarily from the fact that they lived remotely. Nevertheless, at the start of the meeting, each respondent was offered the opportunity to speak alone with the researcher if it was desired. The total interview time ranged from 40 minutes to over three hours, with the
collection of the questionnaire data consuming approximately 15 minutes at the conclusion of the interview about treatment experiences. Each participant was reimbursed $20 for their time at the end of the meeting.

The information gathered was entered into a personal computer and analysed using version 11.5 of the statistical software package SPSS (SPSS, 2003). There were no missing data, although two MCMI profiles were invalidated because they had a raw disclosure score above 179. An inspection of the data revealed the existence of non-normal distributions for each variable, most likely related to the small sample size. As such, the median rather than the mean is reported. In bivariate analyses conducted to assess differences between the clinic and community groups, Pearson’s chi-square tests were used for discrete variables and the Mann-Whitney test was used for continuous variables. The probability value for a two-tailed type I error was set at 0.05. However, given that the research was exploratory, interesting and important differences approaching significance were highlighted.

Results

Demographic Characteristics

The age, gender and years of education and training for clinic and community clients are set out in Table 7.1. As can be seen, community clients were somewhat older than clinic based clients, and this difference was significant, $U=252.5$, $p=0.038$. In order to determine whether age might confound other differences between the client groups, it was entered as a covariate into a post-hoc regression analysis on variables where a statistically significant difference was identified. In no case was age a significant covariate in these models. Table 7.1 also shows that while there were equal numbers of men and women in the clinic group, there were more men than women in the community sector. However, these gender differences across the groups were not significant. Finally, while 38 clients (69% of the sample) appear to have completed an intermediate level of secondary education and 39 (71%) had completed technical training in a trade, there were no significant differences between the client groups in their educational history.
Table 7.1  Age, Gender and Education of Client Sample

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (median years)</td>
<td>31</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>Gender (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>15</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td>Males</td>
<td>15</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Education (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years 7-10</td>
<td>20</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>Years 11-12</td>
<td>10</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Post-secondary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Trade/technical</td>
<td>21</td>
<td>18</td>
<td>39</td>
</tr>
<tr>
<td>University/college</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 7.2 shows the relationship status and the median number of children and children in care of both client groups. As can be seen, the number of clients in each relationship category is similar for both clinic and community clients, with only 18 clients (33%) currently either married or in a de facto relationship. Thirty-nine respondents (71%), consisting of 25 clinic and 14 community clients, reported being parents, and the median number of children for all clients was two. Most of these respondents had no children in their care.

Table 7.2  Relationship Status of Client Sample

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Status (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>De facto</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
<td>10</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Number of children (median)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Number of children in care (median)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The employment status of the client sample is shown in Table 7.3. Twenty-four clients (43.6%) were unemployed at the time of the interview, and a further 12 (21.8%) were receiving either a pension or the sickness benefit, which is a form of government
assistance for individuals too ill to work that is often a precursor to their receiving a
disability pension. By contrast, 19 clients (34.5%) were employed in either casual or
full-time work or engaged in study or home duties. Clinic clients were much more likely
to be receiving a pension than community clients, $\chi^2_{(1)}=6.197$, $p=0.013$.

<table>
<thead>
<tr>
<th>Employment Status (number)</th>
<th>Clinic ($n=30$)</th>
<th>Community ($n=25$)</th>
<th>Total ($n=55$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not employed</td>
<td>12</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Part-time/casual</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Full-time</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Home duties</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pensioner</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Sickness benefit</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Table 7.3 Employment Status of Client Sample*

Treatment Status

The type of pharmacotherapy received by the client sample is shown at Table 7.4. This
indicates that 44 clients (80%) were receiving methadone at the time of interview. Of
the remaining clients being dosed with buprenorphine, more than four times as many
were clinic clients. This difference was significant, $\chi^2_{(1)}=4.125$, $p=0.042$.

<table>
<thead>
<tr>
<th>Treatment Type (number)</th>
<th>Clinic ($n=30$)</th>
<th>Community ($n=25$)</th>
<th>Total ($n=55$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>21</td>
<td>23</td>
<td>44</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

*Table 7.4 Current Treatment Type of Client Sample*

Table 7.5 shows the median number of months clients spent in treatment in the
SAHS program and in opioid replacement therapy overall together with the number of
treatment registrations for each of these categories. As can be seen, the client sample
spent 56 months, or approximately four and a half years, in some form of opioid
replacement therapy, with 36 of those months, or 64.3 per cent of the time, in the SAHS
program. While there was no significant difference between the community and clinic
clients in the amount of time spent in opioid replacement therapy overall, community
clients tended to have spent more time in the SAHS program than clinic clients, \( U=261.5, p=0.054 \). With regard to treatment registration, which is defined as official enrolment as a new client on a program or re-enrolment on a program after more than a continuous one-month break from treatment, there was no difference between the client groups in the number of times they had been registered on the SAHS program. However, clinic clients were much more likely to have been in opioid replacement treatment before than community clients, \( U=227, p=0.008 \).

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Clinic ( (n=30) )</th>
<th>Community ( (n=25) )</th>
<th>Total ( (n=55) )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time in treatment (median months)</td>
<td>SAHS 21</td>
<td>Community 48</td>
<td>Total 36</td>
</tr>
<tr>
<td></td>
<td>Total 60</td>
<td>48</td>
<td>56</td>
</tr>
<tr>
<td>Number of treatment registrations (median)</td>
<td>SAHS 1</td>
<td>Community 1</td>
<td>Total 1</td>
</tr>
<tr>
<td></td>
<td>Total 2</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The number of clients who had exposure to treatments other than maintenance opioid replacement therapy is shown at Table 7.6. Twenty-nine clients (52.7\%) had no experience of other treatments for their opioid dependence while the remaining 26 clients had experience with at least one of a range of treatment types. Those who had tried alternative treatments were much more likely to be in the community sector, \( \chi^2 (1) = 5.145, p=0.023 \). Clinic clients, however, were more likely to have participated in Narcotics Anonymous than community clients, \( \chi^2 (1) = 6.49, p=0.011 \).
Table 7.6 Number of Clients with Experience of Treatments Other Than Maintenance Opioid Replacement Therapy

<table>
<thead>
<tr>
<th>Treatment (number)</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment</td>
<td>20</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>Detoxification</td>
<td>15</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Drug free counselling</td>
<td>10</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Therapeutic community</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
<td>13</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Other (eg. Herbal remedies)</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 7.7 provides details regarding clients' treatment dose, such as its level and stability, and their evaluations of it. While it appears that community clients have a higher median dose than clinic clients, this difference was not statistically significant. As this table shows, the majority of both clinic and community clients reported having adequate (n=50) and stable (n=41) doses.

Table 7.7 Level, Stability and Perceived Appropriateness of Current Dose of Client Sample

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone dose (median milligrams)</td>
<td>50 (n=21)</td>
<td>55 (n=23)</td>
<td>50 (n=44)</td>
</tr>
<tr>
<td>Buprenorphine dose (median milligrams)</td>
<td>8 (n=9)</td>
<td>15 (n=2)</td>
<td>10 (n=11)</td>
</tr>
<tr>
<td>Stability of Dose (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>21</td>
<td>20</td>
<td>41</td>
</tr>
<tr>
<td>Increasing</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Reducing voluntarily</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Reducing involuntarily</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Appropriateness of Dose (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too high</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Okay</td>
<td>27</td>
<td>23</td>
<td>50</td>
</tr>
<tr>
<td>Too low</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Clients were asked to report the number of appointments they had undertaken with their case worker and with their prescriber in the month preceding the interview. (Given that the frequency of client contact with either the dispensing staff at the clinic or the pharmacist was mandated by the requirements of the dosing itself, the number of interactions with these staff was not considered to provide meaningful information on
the amount of contact clients sought from these treatment staff.) Clients in both treatment groups reported having the same number of consultations with their case worker (median = 1) and with their prescriber (median = 1) in the last month.

There were no significant differences between the client groups in their median ratings regarding the need to receive each of the six resource classes as represented by a generic aspect of treatment. In particular, both clinic and community clients rated as very important their need to receive love in the program, which was defined as support and acceptance from staff. Community clients rated as very important their need for status, defined as not being judged or evaluated by staff, while clinic clients rated it as extremely important. Both client groups rated the need for information as very important and the need for goods, represented by an appropriate treatment dose, as extremely important. The need for services, defined as ready access to consultations with staff, was rated as extremely important by clinic clients and very important by community clients. Finally, the need for cost effective treatment, representing the resource of money, was rated as very-to-extremely important for clinic clients and very important for community clients.

Table 7.8 shows the amount of time that clients expected to remain in treatment at the SAHS. Of the 33 clients (60%) who were able to estimate when they would complete treatment, almost half of them (n=16) identified some time within the following three to six months. There were no significant differences between the client groups in their estimation of the time they would remain in the SAHS program.

**Table 7.8 Expected Duration of Opioid Replacement Treatment of Client Sample**

<table>
<thead>
<tr>
<th>Treatment Duration (number)</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-6 months</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>7-12 months</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>1-2 years</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>More than two years</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Don’t know</td>
<td>9</td>
<td>13</td>
<td>22</td>
</tr>
</tbody>
</table>
Drug Use History

The age that clients first used drugs and the type of drug they first used is contained in Table 7.9. As can be seen, there is no significant difference between the client groups in the age at which they first used drugs or what drug it was. For 23 clients (42%), cannabis was the drug first consumed while for 33 per cent of the sample it was alcohol.

Table 7.9 Client Age of First Drug Use and Drug Type at First Use

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of First Drug Use (median years)</td>
<td>14</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>No drug</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heroin</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Illegal methadone</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other opiates</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>10</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Cannabis</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
</tbody>
</table>

Table 7.10 reports the type of drug that clients considered their current problem together with its severity. Seventeen clients (31%) did not consider they currently had a drug problem. Of the remaining 38, 55 per cent (n=21) rated heroin as their primary concern. There were no significant differences between the client groups in the type of drug identified as a problem. Clinic clients rated their problem as more severe than community clients, and this difference was statistically significant, \(U=206.5, p=0.003\).
Table 7.10  Drug Type Identified as Current Problem and Perceived Seriousness of Problem

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriousness of Problem (median)</td>
<td>Moderate</td>
<td>Mild</td>
<td>Mild</td>
</tr>
<tr>
<td>No problem</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Type of Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>14</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Drug (number)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illegal methadone</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Cannabis</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Clients were asked to nominate which drugs, if any, they had used in the month prior to the interview. Those who reported drug use were asked to specify the frequency of use of any drugs during that month and the total amount and regularity with which they were consumed on the last day they were used. The drugs reportedly used by the sample in this period were heroin (n=13); illicit methadone (n=2); other opiates (n=3); amphetamines (n=9); cocaine (n=3); ecstasy (n=1); benzodiazepines (n=2); alcohol (n=14); and cannabis (n=27). The only significant difference between clinic and community clients in their use of these drugs arose with heroin, and this is shown in Table 7.11. Clinic clients were much more likely to have used heroin than community clients, \( \chi^2_{(1)}=9.791, p=0.002 \).

Table 7.11  Client Heroin Use in the Preceding Month

<table>
<thead>
<tr>
<th>Heroin Use (number)</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>18</td>
<td>24</td>
<td>42</td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

Of the clients who used heroin, all had used it once in the past month and in one session on the day it was used. Table 7.12 shows the amount of heroin used by clients on that day. Most clients used between 0.25 and 0.5 gram in that period.
### Table 7.12 Amount of Heroin Used on the Last Day of Use

<table>
<thead>
<tr>
<th>Amount of Heroin (number)</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.125 gram</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>0.165 gram</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>0.25 gram</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>0.5 gram</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>1 gram</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1.5 grams</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Physical Health**

Table 7.13 shows the median number of physical health symptoms reported by clients related to their opioid dependency, related to their injecting behaviour and unrelated to their dependence. While most symptoms experienced by clients appear to be directly related to their dependence, there was no significant difference between the client groups in the number of health problems they reported.

### Table 7.13 Number of Client Physical Health Symptoms, Including Symptoms Related to Opioid Dependence, in the Preceding Month

<table>
<thead>
<tr>
<th>Health Symptoms (median)</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to dependence</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Related to injecting behaviour</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unrelated to dependence</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Psychological Health**

Client profiles for the MCMI were constructed on the basis of scores measuring the presence of a clinical syndrome, which reflects a range of DSM-IV Axis I clinical conditions, and scores measuring the presence of a range of personality patterns, which accords with a number of DSM-IV Axis II personality disorders. Results were recorded for base rate (BR) scores both at or above 75, indicating the presence of clinically significant traits, and at or above 85, indicating the presence of a diagnosable disorder. Fifty clients (91%) achieved a base rate score of 75 or more for at least one clinical syndrome. Thirty-seven (67%) had a score of 75 or more for two or more clinical syndromes. There was no difference between the client groups in these results. Forty-
four clients (80%) had a clinical syndrome base rate score of 85 or more for at least one condition, which indicates the presence of a diagnosable clinical disorder. Table 7.14 shows the range of disorders for which clients achieved the highest base score. As is shown, drug dependence is the most common diagnosable disorder, affecting 23 clients (42%). The second most common is anxiety, which was identified in 10 clients (18%). There were no differences between the clinic and community clients in their likelihood of being diagnosed with either of these conditions.

Table 7.14 Highest MCMI Clinical Syndrome Score Indicating a Diagnosable Clinical Disorder (BR85+)

<table>
<thead>
<tr>
<th>Clinical Syndrome (number)</th>
<th>Clinic (n=30)</th>
<th>Community (n=25)</th>
<th>Total (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of significance</td>
<td>4</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Anxiety</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>12</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>PTSD</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Major depression</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Invalid profile</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Fifty-one clients (93%) registered a base rate score of 75 or more for at least one personality pattern and 42 clients (76%) had a score of 75 or more for two or more clinically significant personality patterns. Thirty-eight clients (69%) had a base rate score of 85 or more for at least one personality pattern, indicating the presence of a personality disorder.

Table 7.15 shows the range of disorders for which clients registered the highest base score. The four most prevalent disorders among the client sample are paranoid personality disorder, narcissistic personality disorder, antisocial personality disorder and depressive personality disorder. Paranoid personality disorder is the most common amongst clinic clients while depressive personality disorder occurs most often among community clients. Narcissistic personality disorder and antisocial personality disorder appear to be similarly prevalent in both client groups. While a Pearson’s chi square test
indicated that community clients were not more likely to receive a diagnosis of depressive personality disorder than clinic clients, there was a statistically significant group difference for paranoid personality disorder, $\chi^2(1)=6.684, p=0.01$.

Table 7.15 Highest MCMI Personality Pattern Score Indicating a Diagnosable Personality Disorder (BR85+)

<table>
<thead>
<tr>
<th>Personality Pattern (number)</th>
<th>Clinic ($n=30$)</th>
<th>Community ($n=25$)</th>
<th>Total ($n=55$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of significance</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Schizoid</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Avoidant</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depressive</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Dependent</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Antisocial</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Masochistic</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Paranoid</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Sadistic</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Invalid profile</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

A comparison was also undertaken of the response styles of both client groups as indicated by their results on the three modifying indices. The first index, the disclosure scale, measures the degree to which clients over- or under-report symptoms. The second, the desirability index, measures the extent to which clients seek to portray themselves in a positive light. The final index, the debasement scale, measures the degree to which clients exaggerate complaints and problems. An elevation on this scale may be indicative of a negative evaluation of the self. While the calculation of the base rate scores for the clinical syndromes and personality pattern scales incorporates the influence of the modifying indices, and that is their main purpose, in themselves they provide information about each client’s style of responding to such questionnaires. Table 7.16 shows the median scores for community and clinic clients for each modifying index. As can be seen, there was no difference between the client groups in either their desirability or debasement scores. However, clinic clients appeared to have a higher level of disclosure than community clients, which suggests that they were
much more open and spontaneous in providing responses to the questionnaire. This difference was significant, $U=236.5, p=0.043$.

Table 7.16  MCMI Modifying Index Scores

<table>
<thead>
<tr>
<th>Modifying Index (median)</th>
<th>Clinic ($n=30$)</th>
<th>Community ($n=25$)</th>
<th>Total ($n=55$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure scale</td>
<td>76.5</td>
<td>67</td>
<td>72</td>
</tr>
<tr>
<td>Desirability scale</td>
<td>65</td>
<td>59</td>
<td>65</td>
</tr>
<tr>
<td>Debasement scale</td>
<td>68</td>
<td>59</td>
<td>64</td>
</tr>
</tbody>
</table>

**Social Functioning**

Clinic clients achieved a median social functioning scale score of 14 ($32^{rd}$ percentile) out of a possible 44 while for community clients it was 11 ($25^{th}$ percentile). This difference was significant, $U=218, p=0.008$. This suggests that community clients experienced higher levels of social support, less conflict in their personal relationships, less involvement in drug using networks, greater occupational and residential stability and fewer personal crises in the month prior to interview.

**Global Assessment of Treatment Quality (CSQ)**

Clinic clients recorded a median satisfaction score of 57 ($79^{th}$ percentile) out of a possible 72 while for community clients it was 54 ($75^{th}$ percentile), indicating that both groups of client tended to report being satisfied with a range of aspects of treatment. There was no difference between them in their ratings of the overall quality of the treatment environment.

**Discussion**

This general aim of the study reported in this chapter was to assess the psychosocial profiles of clinic and community based clients of the SAHS to determine whether there are any notable differences between them. This would lend support for the current policy practice upon which functionally stable clients are encouraged to move to the community sector as well as highlight areas where either client group may have special needs that shape their expectations of treatment. In particular, it was considered that
Clinic based SAHS clients would have less experience with treatment; greater illicit
drug use during treatment; poorer physical and psychological health and social
functioning; and a more negative reaction to the treatment environment as a whole.

The results indicate that community based clients were significantly older and
had spent longer in the SAHS than clinic clients. This age difference, however, had little
influence on other identified differences between the client groups. Clinic clients were
more likely to have had more attempts at opioid replacement treatment and Narcotic
Anonymous than community clients, though community clients appeared to have tried a
greater range of treatments for their opioid dependence. Clinic clients in this sample
tended to regard their current opiate problem as more severe than community clients,
and they were more likely to engage in concurrent heroin use during treatment. While
there were no physical health differences between clinic and community clients, clinic
clients were more likely to be diagnosed with paranoid personality disorder than
community clients regardless of their tendency to be more open about their problems.
Clinic clients were also more likely to have poorer social functioning than their
community counterparts.

Beyond these differences in the client groups, a number of characteristics make
a notable contribution to the profile of the overall client sample in this study. Over 60
per cent of clients were found to be in receipt of some kind of social welfare as their
main form of income and to not receive personal support via an intimate relationship.
Eighty per cent of clients met the criteria for at least one clinical syndrome. This was
most commonly drug dependence, which was identified in 42 per cent of the sample.
However, 18 per cent of clients met the criteria for anxiety. Sixty-nine per cent of
clients met the criteria for at least one personality disorder, the most common being
paranoid, narcissistic, depressive or antisocial personality disorder. Eighty per cent of
clients were receiving methadone and most clients described their dose as stable and
adequate. All clients reported a low level of contact with their case worker and
prescriber in the month preceding the interview. While over half of the clients who
could identify an end point in their treatment reported an expectation of completing
treatment within the following six months, all clients reported a high level of need for a
range of resource types while in treatment. All clients regarded the treatment environment as satisfactory.

The demographic features of the clients sampled in this study generally accord with those of other Australian samples. The clients were slightly older than those reported in recent studies (Mattick et al., 2004), which reflects the general ageing of the cohort of drug users in treatment. The more advanced age and treatment experience of community clients is also consonant with this conclusion. Like other reported samples, however, most clients in this study were male, had a junior secondary level of education and were dependent on some form of income support.

Clinic clients in this study were found to be more likely to use heroin while in treatment and to have had more attempts at engaging in treatment than community clients even while tending to report having an appropriate treatment dose. This result suggests that clinic clients may have more ambivalence about treatment and are possibly using it to control rather than eliminate their drug use. Such a conclusion is also consistent with the comments of several clinic clients in the focus groups reported in Chapter 6. All clients reported high levels of need for a range of interpersonal resources while in treatment, which is similar to findings in studies of North American methadone maintenance clients (Teichman, Teichman, Converse & Foa, 1992). However, clinic clients indicated a slightly stronger need to receive cost effective treatment and to engage with non-judgmental, non-stigmatising treatment staff. If such needs remain unfulfilled and clinic clients have an expectation that they should be provided for, they may become disappointed and relapse to drug use or drop out of treatment. Accordingly, realistic client treatment goals have been found to exert a positive effect on retention early in treatment (Simpson & Joe, 1993).

Like the results of other research involving the MCMI (e.g. Ball et al., 2004; Teplin, O'Connell, Daiter & Varenbut, 2004), the clients in this study were found to have high levels of psychiatric disturbance. As would be expected in an opioid substitution program, drug dependence was the most common Axis I clinical condition. Like previous research, clients with significant Axis II antisocial and narcissistic
personality traits were identified in this sample (Ball et al., 2004). Paranoid personality disorder was the most prevalent condition, however. Earlier versions of the MCMI have been criticised for overdiagnosing paranoid personality disorder in substance abuse samples because of the item overlap in the paranoid and drug dependence scales (Craig & Weinberg, 1992). Given it is unclear to what extent this is a problem with the third version of the MCMI, this result may need to be considered with caution. Despite this rider, paranoid personality is rated as one of the severe personality disorders, representing a ‘blend’ of the more dysfunctional variants of the narcissistic and antisocial personality patterns (Millon et al., 1997:125). Individuals diagnosed with this disorder display a pervasive mistrust of others and are defensive against anticipated criticism or deception. They tend to invite exasperation and anger in others because of perceived threats to their independence. Paranoid individuals tend to vigorously resist external sources of control, which leads to troubled interpersonal relationships (Millon et al., 1997). Together with the lower levels of social functioning and higher levels of illicit drug used identified in clinic clients, these results suggest that clinic clients are more likely to have unmet expectations and to report more unsatisfying treatment experiences.

In conclusion, clinic and community based clients of the SAHS have similar demographic profiles. While community clients are older than clinic clients, this age difference bears little influence on their comparatively lower drug use, longer and more stable treatment experience, and greater psychological and social functioning. While both clinic and community clients appear to evaluate the SAHS treatment environment positively, the degree to which this is borne out in their subjective reports of treatment, taking into account their psychosocial differences, will be examined in the following chapter.
Chapter 8 – Client Satisfaction with Opioid Replacement Treatment in the Southern Area Health Service: Respondent Evaluations

As noted in Chapter 2, the gradual restructuring of opioid replacement treatment in Australia over the last 20 years and its more recent expansion into the community sector means that little is known about the effect of the current clinical settings on client responses to treatment. The research that is available indicates that, in contrast to traditional public sector clinics, the format and operation of private sector treatment, particularly in the community, produces a unique set of conditions that impact on treatment effectiveness (Bell et al., 1995; Lintzeris et al., 1996). The ability of service providers working in isolation to effectively manage day-to-day relationships with clients; the use of treatment fees; the structure of dosing arrangements; and client access to ancillary services such as counselling and medical treatment are examples of these factors. One of the aims of this thesis is to expand current knowledge about client responses to these features of the current form of treatment. The Southern Area Health Service (SAHS) opioid replacement therapy program was considered apt for this purpose because clients can receive treatment from either its private sector or public sector component and are likely to experience both during their time in treatment. An examination of client satisfaction with treatment was deemed to be the most appropriate manner of cataloguing client reactions to this program.

A second aim of the thesis is to develop a model of client satisfaction suitable for conducting the above evaluation. The review of the literature on client satisfaction with opioid replacement therapy in Chapter 3 highlighted that attempts to measure treatment effectiveness by correlating certain program or client factors with single global measures of client satisfaction have produced mixed and sometimes contradictory results. As was shown, one explanation for this is that client evaluations of events are usually based on a comparison to some standard, such as an expectation of what would or should have happened, and most quantitative measures cannot capture this relativity. Further, the items selected as important for evaluation are usually not
those chosen by the client. Finally, most client satisfaction studies fail to examine the effect of satisfaction judgments on client behaviour in treatment.

The model developed to assess client satisfaction in the SAHS opioid substitution program presumes that satisfaction judgments relate to clients' expectations of treatment and that expectations exert a non-linear influence on these judgments. As such, the types of expectations producing different client responses to treatment require identification. Minor discrepancies between clients' expectations and their treatment experiences tend to result in reports of satisfaction because they are assimilated. In other words, clients are likely to report satisfaction if their expectations regarding probable or predicted treatment scenarios are unmet in minor ways. However, large differences between client expectations and experiences result in dissatisfaction. This is usually because the treatment does not meet their normative standards. This variation in the effect of the different types of unmet expectations is an indication of the seriousness or importance clients attach to the issue. The model proposed in this thesis argues that client tolerance for breaches of normative expectations regarding some aspect of treatment is likely to be lower if clients have a personal need in that area. Finally, when their treatment norms are not met, clients are likely to express their dissatisfaction behaviourally.

The general aim of this study is to identify which areas of the SAHS Opioid Agonist Treatment Service clients regard as satisfactory and which areas they evaluate as unsatisfactory using this theoretical model of client satisfaction. Aspects of treatment clients nominate as important will be classified according to a resource class in order to identify any differences between their response to the components of treatment and their response to the way those components are delivered. The study will identify the source of client judgments about treatment and their impact on both the clients themselves and their relationship to the program. This translates to three specific aims. First, the normative and predictive, or probabilistic, expectations on which client evaluations are based will be established. Second, the conditions under which these expectations are activated will be identified. This could include features of either the clients or the area of the program in which they receive treatment. Third, the effect of unmet expectations
on clients' responses to significant treatment events will be examined. In particular, this
will require identifying the impact, if any, on the clients and/or their involvement with
either treatment staff or the program more generally.

Method

Design

The interview was to be designed to be essentially informal and conversational in style so
that a level of depth could be established with each of the respondents on issues
nominated by them as relevant to their individual circumstances in the program.
Conversational interviewing requires the researcher to follow the direction of the
interview set by the respondent yet ensure its purpose is kept in focus. Given that no
predetermined set of questions can be developed in such circumstances, the quality of
information obtained in such unstructured interviewing is highly dependent on the
quality of the questions that can be developed in a spontaneous exchange. Insights must
be generated rapidly so that questions on the topic of interest can be developed
smoothly and rapport can be established and maintained. While summaries of responses
may be reflected back to respondents to encourage the elaboration of ideas or clarify
earlier answers, the structure of the questions must also not impose an interpretation on
the respondent's situation or opinions (Patton, 1990). Data well gathered from this form
of open-ended interview, however, usually reflect the respondent's full repertoire of
responses to a situation and the language used to define his or her world view or life
context.

Participants

The respondents recruited to the study are described in Chapter 7.

Materials

In order to allow the researcher to maintain control of the interview while being led by
the respondent in the choice of topic, a simple interview schedule was developed and
memorised. It is shown at Table 8.1. As can be seen, it lists a standard opening question
for each respondent, a prompt for those who respond with confusion to the initial
question or seek guidance about how to proceed as well as a set of probes based on the issues raised in the focus groups reported in Chapter 6. The probes were used only for those respondents who had difficulty identifying any issue or event of importance to them in the program.

Table 8.1 Interview Schedule for Clients

1. I'd like you to think about the time you've spent on the program in the Southern Area Health Service and whether during that time there have been any significant or memorable issues or incidents for you regarding the program. When I say 'significant or memorable', I mean that after they happened you might have thought a bit about them or had strong feelings about them, either good or bad, and it might have even changed the way you started to think about the program or even yourself. Does anything come to mind?

2. (If the client seeks guidance with the first question) For example, do you have a case worker/doctor/pharmacist (select provider with whom the client is likely to most frequently engage)? How do you find that?

3. Probes (choose those applicable to the client's circumstances only if the client cannot think of anything to say): What do you think about: takeaways; transfers; getting access to the program or providers; the need for counselling, urine tests; the cost of treatment; dose levels; getting served at the pharmacy/clinic?

Procedure

The method of recruiting and interviewing the study participants is reported in Chapter 7.

Each interview was transcribed verbatim by the researcher using RapidWrite Pro 1.02 (Stenograph, 2001) shorthand translation software. Data analysis was conducted in three stages. The first stage was essentially a mapping exercise using descriptive coding categories to identify and analyse issues and events rated by each respondent according to the features of the proposed model of satisfaction. A coding system developed by the researcher was employed specifically for this purpose. (Detailed instructions regarding the use of the system are outlined in Appendix F and a sample of the instrument developed for registering the codes is supplied at Appendix G.) In summary, once an issue or event was identified, it was analysed in respect of the following six features:
• its valence for the respondent, being either positive or negative;
• its source, being either one of the three main service providers—namely, the case worker, prescriber or dispenser—or the program itself;
• whether or not it appeared important to the respondent;
• the meaning attributed to it by the respondent as suggested by a particular resource class;
• whether or not the respondent’s expectation in relation to it was met; and
• its outcome for the respondent and/or the program based on his or her attitudinal or behavioural reaction to it.

Initial descriptive coding by the researcher using this system yielded 552 events and issues nominated by the 55 respondents, of which 505 were rated as important. In order to determine the reliability of the coding, a doctoral student at the university with experience in textual analysis was trained in the system. Inter-rater reliability tests were then conducted on a random selection of five transcripts, equating to almost 10 per cent of the sample, from which a standard minimum of 30 coding units could be readily derived (Lacy & Riffe, 1996). The percentage of agreement between the coders was 92.15 per cent for identifying the same events or issues, with one coder identifying four more issues or events (n=51) than the other (n=47). These codes were reviewed and added to the list of classifiable issues or events, bringing the total to 556, with 507 identified as important. Cohen’s kappa statistics were calculated on the remaining 47 issues and events to determine the extent of coder agreement over the classification of their components. A value of 1.0, indicating perfect agreement, was found both for the valence of the issues or events as well as their source. A value of 0.92 was found for importance; 0.89 for the resource category; 0.84 for the expectation; and 0.82 for the outcome, all of which indicate a satisfactory level of coding reliability (Murphy & Davidshofer, 2001). Each coding discrepancy was then reviewed, and this resulted in two codes being amended.

The second stage of the analysis involved reordering and aggregating the data to identify themes and trends related to the operation of the proposed client satisfaction
model. Frequency counts were used in this stage of the analysis as they provided the
greatest check against analytical bias. Tables of frequencies are illustrated in this part of
the procedure section principally to highlight the logic of the data analysis. While they also
represent preliminary results, the general patterns contained within them are only
commented on cursorily as their detail is considered in the results section.

Given the large number of issues and events nominated by the respondents, it
was decided that only those rated as important would be subject to further analysis. (For
a discussion of the criteria for rating an event or aspect of treatment as important, see
section E of Appendix F). Each of the 507 issues and events was organised according to
one of four outcomes based on the valence of the event and the two main outcome
classifications—namely, a behavioural or attitudinal client response. This resulted in the
following four possible outcomes: a negative behavioural outcome; a negative
attitudinal outcome; a positive attitudinal outcome; and a positive behavioural outcome.
The items in each of these groups were then sorted by resource category and whether
they were reported by a community based client or a clinic client. The number of issues
and events falling into each of these categories is shown at Table 8.2. As can be seen,
several individual categories, particularly for the resources of love and services, contain
numerous issues or events. There is also little differentiation between the number of
items presented by clinic and community clients for status and services or between the
number of positive and negative attitudinal items for goods, status and services.
Table 8.2 Number of Important Issues or Events by Client Type, Resource Category and Outcome

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total</th>
<th>Love</th>
<th>Status</th>
<th>Services</th>
<th>Information</th>
<th>Goods</th>
<th>Money</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Clinic</td>
<td>Community</td>
<td>Clinic</td>
<td>Community</td>
<td>Clinic</td>
<td>Community</td>
<td>Clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love</td>
<td>125</td>
<td>6</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>45</td>
<td>36</td>
<td>4</td>
</tr>
<tr>
<td>Status</td>
<td>98</td>
<td>13</td>
<td>16</td>
<td>20</td>
<td>21</td>
<td>11</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Services</td>
<td>172</td>
<td>22</td>
<td>11</td>
<td>41</td>
<td>33</td>
<td>26</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Information</td>
<td>15</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Goods</td>
<td>63</td>
<td>8</td>
<td>3</td>
<td>12</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Money</td>
<td>34</td>
<td>7</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>507</td>
<td>56</td>
<td>45</td>
<td>91</td>
<td>80</td>
<td>101</td>
<td>116</td>
<td>7</td>
</tr>
</tbody>
</table>

In order to identify clearer trends in respondent evaluations of these items and achieve a more refined or differentiated level of analysis, the six resource categories were partitioned. This was achieved by reviewing the issues and events in each resource category and subjecting them to a thematic cluster analysis, whereby items with the least individual variation in meaning were compiled into groups showing the greatest degree of distinctiveness. This process resulted in the creation of 17 subset codes across the six resource types, the definitions for which are reported at Appendix H. The breakdown of events and issues into these codes is shown at Table 8.3. As is shown, while the number of items for analysis in each subcategory is notably smaller, the distinctions between clinic and community clients on issues represented by the subset codes is sharper as is the difference in the valence of each code. For example, both clinic and community clients have more positive than negative experiences for issues involving goodwill, while the reverse is somewhat true, though a little more complex, for issues regarding respect. Partitioning the items in the resource categories in this way thus focused the analysis of the trends in the data.
Table 8.3 Number of Important Issues or Events by Client Type, Resource Category Subset and Outcome

<table>
<thead>
<tr>
<th>Resource</th>
<th>Negative Behaviour</th>
<th>Negative Attitude</th>
<th>Positive Attitude</th>
<th>Positive Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinic</td>
<td>Community</td>
<td>Clinic</td>
<td>Community</td>
</tr>
<tr>
<td>Goodwill</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Genuineness</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Love</td>
<td>Warmth</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Acceptance</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Respect</td>
<td>2</td>
<td>11</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Status</td>
<td>Stereotype</td>
<td>5</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Exposure</td>
<td>8</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Services</td>
<td>Dosing Time</td>
<td>9</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Facility</td>
<td>3</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Rules</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Consultation</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Information</td>
<td>Information</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Goods</td>
<td>Drug</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Drug Level</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Money</td>
<td>Treatment</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Late Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A separate yet relevant aspect of this stage of the analysis was determining the source of issues or events in the program. More specifically, this involved examining whether a service provider or the program generally was consistently associated with particular aspects of treatment. As such, the issues and events in each main resource category were tabulated according to their valence and whether their source was the program, the case worker, the prescriber or the dispenser. They are shown at Table 8.4. As can be seen, dispensers are associated with predominantly negative events, mostly involving issues of status. Prescribers are identified with mostly positive events.
typically involving love. The respondents associate an almost even mix of positive and negative events with case workers and these relate to issues of love and status. Finally, the program is seen in mostly a negative light with regard to issues involving goods and services.

Table 8.4 Number of Important Issues and Events by Source, Resource Type and Valence

<table>
<thead>
<tr>
<th>Resource</th>
<th>Program</th>
<th>Case Worker</th>
<th>Prescriber</th>
<th>Dispenser</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
</tr>
<tr>
<td>Love</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>46</td>
<td>43</td>
<td>81</td>
</tr>
</tbody>
</table>

Following the categorisation of the data against each component of the conceptual framework, the third stage of the analysis involved an holistic assessment of the relationships among the categories and the development of a set of propositions regarding the structure and operation of client expectations underpinning each type of issue or event. In particular, this part of the analysis had the aim of identifying the nature of the expectations shaping client responses to treatment as well as the contingencies under which unmet client expectations would be acted upon to produce different kinds of outcomes for either clients and/or the program. Several strategies were used to achieve these ends. For each of the 17 types of issues and events, a series of comparisons and contrasts were made among the four outcome classifications. This aimed to highlight any similarities or distinguishing features of either the program or the profile of the clients that resulted in issues or events being associated with a particular client outcome. The criterion for determining the merit of any variable identified from this process was its practical significance for either the program or the
clients. These variables were hypothesised to be the set of contingent conditions upon which client expectations would produce a variety of treatment outcomes. These variables were then removed from further consideration for each type of issue or event so that a second-order factor common to each type of outcome could be identified. This factor was hypothesised to be the expectation underlying each issue or event.

The contingent conditions and expectations for each type of event or issue were then compared across the framework of the 17 different types of issues and events in order to determine whether they could be better accounted for by fewer, more abstract categories. Following this, a final set of propositions regarding the structure and operation of the proposed set of expectations was developed. This took the form of a series of if-then relationships, and these were constructed to test the ability of the proposed expectations to account for client attitudes and behaviour in treatment given the presentation of certain types of treatment events. These hypotheses were tested by applying them to randomly selected client case data and assessing their ability to account for the obtained events. Explanations were developed to account for any results that deviated from or contradicted the propositions. The utility of the explanations regarding the nature of client expectations and their operation was considered adequate when they could be shown to reliably produce a particular outcome regardless of the type of event or issue.

In summary, the process of analysis proceeded in three stages. The first involved the classification of the data according to the set of descriptive codes developed from the model of client satisfaction. A coding system was employed for this purpose. The second stage involved an aggregation and reorganisation of those codes to identify relationships in the data and highlight issues relevant to different client groups and outcomes. A cluster analysis and frequency counts were the main means by which this was achieved. The final stage of the analysis was essentially a synthesising activity in which the major themes in the data were assessed to identify the expectations underpinning client attitudes and behaviour in treatment and the set of conditions under which they would produce particular outcomes. Category comparisons and factor
analytic techniques were used to develop the final explanatory framework that resulted from this process.

Results

The results are presented in two parts. The first details the expectations and conditions considered to directly impact on each of the 17 types of issues or events identified by the respondents as important in the treatment program, including features of either the program or the respondents' profile where clear patterns were found to exist. Verbatim quotes from the respondents are used to highlight the significance of the issue or event for their participation in, and reaction to, opioid replacement treatment. This section of the results accords with the material identified from the second stage of the data analysis described in the previous section. In accordance with the proposed theoretical model, negative behavioural outcomes from events and issues are considered to be instances of client dissatisfaction. Negative attitudinal responses are regarded as disappointments, not dissatisfaction, however, because they involve breaches of probabilistic or predictive expectations which are ultimately assimilated by the client. Positive attitudinal responses are reported as pleasant surprises when clients had predicted the outcome to be more negative than it was.

The second part of the results section describes the final explanatory model derived from the patterns detailed in the first part. For the sake of conceptual coherence, it is presented in four parts according to two dimensions—namely, the effect of either satisfaction or dissatisfaction on client responses to treatment; and whether the issue relates to either the process of treatment delivery or the content of the treatment itself. The model documents the aspects of treatment where expectations are likely to be activated, the normative and predictive expectations involved, the particular types of clients who are most likely to respond when these expectations are either met or breached, the area of the program within which they are based and the effect on either the client or the program of their satisfaction or dissatisfaction.
Exchanges of Love

Goodwill: The respondents described 41 accounts of unexpected positive experiences where the main providers of treatment demonstrated an interest in them as individuals as well as showed devotion to improving their wellbeing. These events were nominated most frequently by clinic based clients and largely related to their opinion of either the prescriber or case worker. Typical examples of provider goodwill cited by clients were the prescriber’s interest in their general health, particularly for issues such as depression, or preparedness to spend time fixing problems with prescriptions. Clients also valued case workers visiting them in jail, providing telephone contact following missed appointments and arranging temporary transfers well within the timeframes specified by the clinic rules. In reflecting on the impact of these situations, the respondents reported feeling ‘cared for’ by, and ‘more comfortable’ with, their provider, which resulted in their also feeling ‘enthusiastic’ and ‘hopeful’ about their treatment prognosis. In seven instances, six of which were provided by community clients, provider demonstrations of goodwill towards clients resulted in positive behavioural outcomes, with clients identifying an increase in their honesty with the provider and more frequent contact with the service as examples of this. The significance of simple gestures of goodwill in improving the everyday treatment relationship is highlighted in the following report, which is provided by a client who indicates that he has no need for formal counselling, where opportunities for interpersonal exchanges of this type would be generally most expectable:

I burnt me hand. I dropped a screwdriver on the motor of the truck and I put me hand down. I burnt it on the manifold and all that. I don’t know the [dosing] lady’s name, but, yeah, she was quite—she said, ‘Are you all right? Do you want some Benedine?’, and things like that, you know. Because I’ve got no-one else to look after me like that, so that’s good, you know. I like that, yeah. And it was genuine. I could tell that she wasn’t—I suppose some around here just pick up their money, but I haven’t met them here yet. But at [interstate program] there were some that were just—it was just a job.

Q. And how did you sort of know that some were genuine? How do you tell?
A. I just can. You just can, you know. Say, ‘Good morning. Have a nice day. How’s work?’ you know, that sort of thing.

Q. And how does that kind of make you feel?
A. Oh, it’s good, especially if you’re, you know, not feeling too good about yourself. Because I’m single and my parents sort of—see, I’ve got no-one really to ask
me those sort of things, you know. But when I come here, you know—because I’ve never had counselling, although I’ve had plenty of offers, you know—they say, ‘Look, we can counsel you’ and that, but at this stage I’ve never needed it. (Clinic client)

In 14 instances, or one-third of cases, the respondents’ overall low expectation of goodwill from providers was attributed to prior negative experiences with providers in other treatment programs. Conversely, and in addition, in three of four cases where the respondents, all clinic clients, reported disappointment at the lack of interest shown in them by providers, it was because of prior positive experiences with providers on this issue. However, no clients registered dissatisfaction with the degree of goodwill shown by program staff, which is indicated in the model by negative behavioural responses. Notably, 12 of the 24 events resulting in positive attitudinal changes for clinic clients were provided by all seven clients found to have a diagnosable paranoid personality as described in Chapter 7.

**Warmth:** The respondents described 20 instances of favourable attitudinal change towards treatment providers in response to friendly or positive emotional interactions where they felt recognised or valued as an individual by the provider. To an almost equal degree, clinic and community clients spoke with fondness and appreciation of providers with whom they shared a warm engagement. Usually these were either the dispenser or the prescriber. In three cases, these experiences had positive behavioural outcomes, with two clinic clients and one community client indicating a willingness to be more honest and upfront or genuine in their relationship with the provider or to seek out the particular individual concerned when faced with other problems. Having a treatment relationship in which both parties are able to express their liking or affection for one another, such as through badinage, was also found to make the rejection of client requests by the provider more tolerable to the client, as the following example indicates:

Dr [nickname], I have a great relationship with him. He’s like a father to me, in a sense. Like, I can say what I want to say—anything about the clinic or what I do on the outside or how his life is going, or how is his grandsons or kids or whatever [are], do you know what I mean? So I have a very good relationship with my doctor. He doesn’t ever give me what I want, but I still have a bloody good relationship because he knows me, you
know. I ask him for Valium and he just laughs at me because he knows I’m having a go at him or something. I don’t mind having a joke with him. But he’s cool. (Clinic client)

Of the 20 positive cases of provider warmth described by the respondents, half were reported to be expected. Five respondents, four of whom were based in the community, described disappointing interactions with dispensers on this issue though not outright dissatisfaction inasmuch as they would act on their disappointment. Four of these clients also appeared to expect some degree of warmth from program staff. For the community clients who reported negative experiences, the providers were described either in sarcastic terms or simply as ‘moody’, ‘grumpy’ and ‘inconsistent’ in their interpersonal manner towards clients. All four of these clients appeared to lower their expectation to accommodate their experience after noting that other customers or staff associated with the providers were treated in a similar way. The clients then did not feel impelled to respond to the interpersonal style of the providers as it could be attributed to the ‘personality’ or ‘stress’ of the individuals concerned. Nonetheless, coldness or distance from a provider induced a degree of reticence by clients towards the treatment relationship, as shown by this couple’s report:

B. ...As I said, when I first rang up, [the pharmacist] sort of got on the phone and he said [sharply], ‘Yep’, and I said, ‘Have you got any vacancies?’ ‘Yep. Get your doctor to sort it out.’
A. Even the doctor got a mouthful.
B. And then the next time I rang him to just—before we were coming down to make sure, because I thought otherwise I’ll have to go to the hospital, and he said, ‘I told you I didn’t want you to ring me. I want everything faxed.’ I thought—I said to [partner], ‘This isn’t going to work out. I can just see it.’ And then we got down here. Well, then the doctor actually rang, and he was rude to our doctor. She said, ‘Oh, you know, how are you going to go with that?’ I said, ‘Oh, I don’t know.’ Then when we got...
A. [sarcastically] Perfect!
B. ...down here, everything that we had faxed, he said—like, we went and got photos taken, you know passport sized ones, and he said that we had to fax that to him with our script and everything, so we did that. And then he said, ‘I can’t see these photos. You’ll have to go get the photos done again.’
A. But, then again, after that, he’s been okay.
B. Yeah.
A. He’s one of those sort of men that he wants it his way and that’s it, so you’ve just got to play your game.
B. Yeah.
Q. Is that different from how you expected it to be or think it should be in any way?
A. I think—I expected that from him only through what he said to our doctor. But, no, I don’t think it should be like that.
B. Be approachable. (Community clients)

**Genuineness:** The respondents provided 10 evaluations of treatment based on the degree to which program staff were upfront in their expression of feelings, prepared to be self-disclosing and able to be honest and non-defensive in their approach to clients. Of these, eight took the form of pleasant surprises, particularly for community based clients, who reported that they ‘respected’ and valued having a ‘straight talking’ case worker and/or prescriber. For one clinic client, having a case worker who communicated with her in an authentic and spontaneous way resulted in her seeking assistance from that provider for problems when previously she had avoided the service. While no clients reported dissatisfaction with the genuineness of program providers, one clinic client interpreted inconsistency in the attentiveness of dispensing staff towards him as disingenuousness. The value he placed on sincerity was made by way of immediate comparison with his treatment by the prescriber:

A. Dr [name], he’s fine, he’s great. He’s a good...doctor. Yeah, he’s good. He’s real good, yeah. Yeah, he is.
Q. What is so good about him?
A. He’s down to earth. At least you can talk to him and he’s sincere. You can have a decent conversation with him and you know he’s sincere. He’s not, like, trying to hurry you up or push you out the door. You know, he’ll drop his pen and he’ll lean back and talk to you. I talk to him about everything...When he was a kid he used to [relays details of the prescriber’s childhood] and all that stuff, and everything, and all that, you know. Yeah, he’s sincere.
Q. What does that mean to you that he would do that, be like that?
A. Well, that somebody cares. It means that he cares. Yeah, that he cares for you. Talking about his old childhood and all that stuff. He cares. Before people get involved with you, kind of thing, you should know their life. You’re sincere and all that, you know. [Provides more details of the prescriber’s childhood.] He talks about that stuff, yeah. It sounds sincere, that stuff. (Clinic client)

**Acceptance:** The respondents supplied 19 examples of the importance of providers adopting an attitude of neutrality towards, if not support of, clients despite their sometimes poor choices regarding treatment or different personal values. In 12 cases, more frequently involving clinic clients, the respondents described positive
feelings of ‘hope’ and ‘confidence’ following the unexpected receipt of acknowledgement or even support for their perspective from either their case worker or prescriber, particularly when those providers were perceived to ‘have nothing to gain by being supportive’. Seven instances of non-accepting attitudes on the part of providers resulted in negative behavioural outcomes for five clients, four based in the clinic and one in the community, all of whom were continuing to use heroin at the time of interview. For one client, who perceived her provider’s public lack of endorsement as humiliating, the incident resulted in her transferring to another dosing location in the program. For three clients, the event resulted in their psychological withdrawal from the treatment relationship. The following account shows how a prescriber’s failure to recognise and validate the client’s treatment preference resulted in the client’s relational disengagement from that provider:

Q. So you sound a little disappointed in some way that [the prescriber] is kind of so—it’s like a little bit of a ‘yes-no’ thing?
A. I think the first year I was getting dosed through him, I asked to see—I wanted a referral and I’d asked to see a woman and he gave me one to this man who was very nice, but, yeah, I couldn’t talk to him. {crying} Sorry.
Q. It’s pretty important to have someone that you know actually gets it and that you can talk with.
A. Well, yeah. And, yeah, just—it just made me feel like he felt it wasn’t important. {crying} and that I was attaching far too much significance to something that he thought, you know, shouldn’t be relevant. And you’d think that, regardless of what he thought, if I thought it was important, then that should have meant something.
Q. So he pretty well dismissed it and dismissed you?
A. Yeah, pretty much, yeah. Yeah, he just wasn’t interested. (Community client)

Respect: There were 26 evaluations regarding the degree to which treatment staff maintained an expected level of psychological distance from clients by upholding the protection of client privacy and having trust in the capacity of clients to adequately care for themselves. Sixteen evaluations were negative, and 13 resulted in behavioural responses from clients, overwhelmingly by those based in the community. An examination of these cases showed that in eight instances the respondents were dissatisfied with three providers relaying details of their personal life or ‘telling lies’ about their character to either other clients, family members or other authorities in the local community. In all of these situations, the respondents complained to another
clinician in the service and had only minimal essential contact with the original provider thereafter. The remaining five expressions of dissatisfaction concerned respondent perceptions regarding the providers’ lack of trust in clients manifested in their searching clients on suspicion of theft from the pharmacy, dispensing other medication in low doses to prevent overdose and relinquishing takeaway allowances on suspicion of diversion. In response to these actions, the study participants reported changing providers or complaining to the individual concerned. Negative experiences with regard to providers trespassing on the personal life of clients were relayed with much consternation by the respondents due to their impact on other relationships in their life, as the following example shows:

[Former wife], that’s me ex, anyway... And she was friends with a woman down here called [case worker]. And [case worker] is sort of like the case worker for a lot of people. And I got on the program down here, so straight away [case worker] shot her mouth off to my ex in [home town] about what I was doing. My ex told my eldest son up in [home town] and he’s told my parents, who are in their 70s, and they didn’t need to know about it, you know... I was so angry about that. (Community client)

The 10 positive evaluations of program staff on the issue of respect were also mainly provided by community clients. These respondents appreciated their providers, who were usually prescribers, maintaining confidences, inviting them to exercise discretion in disclosing their treatment status to other authorities and not seeking personal information perceived to be irrelevant to their performance on the program. In considering the positive aspects of his relationship with a program prescriber, one study participant spoke about the likely effect of provider intrusiveness in this way:

Q. So it sounds like you actually appreciate the fact that he doesn’t need to prod or probe you?
A. Yeah, yeah, yeah. That’s what I don’t like because it’s like—it’s almost like you’re sitting there being expected to spout information, you know, and you’ve got nothing you want to say, nothing to say. But they’re digging, kind of thing, and it’s like, ‘Hey, I’ve got nothing to say. If you want me to start bullshitting, you can keep digging and I’ll tell you bullshit.’ {laughs} (Community client)
Exchanges of Status

Stereotype: A total of 56 events were identified by respondents regarding the management of the expected stigma of their social status as methadone or buprenorphine clients. The source of this stigma was attitudes from either the treatment providers or those with knowledge of the respondents’ enrolment on the program, such as family and employers, impugning the character of former heroin users. Thirty-five of these events were negative, including 10 expressions of dissatisfaction, and most were raised by clinic clients. Examples of staff behaviour interpreted by the study participants as evidence of discriminatory attitudes towards clients included comments on client dress standards; withholding doses because of intoxication from drugs other than opioids; rudeness at program clients and not other customers of the provider; and conducting random urine testing on demand. Instances of negative stereotyping experienced simply through the respondents’ participation on the program related to problems acquiring and maintaining employment once their treatment status was known to the employer. Of the five instances of dissatisfaction registered by clinic clients, all of which related to perceived negative stereotyping by either a case worker or dispenser, this resulted in their moving to another dosing site on the program, resuming illicit drug use, withdrawing from the relationship with the provider or complaining to the manager of the service. The community clients who reported dissatisfaction did so also in relation to a treatment provider, and all complained to the provider concerned.

A comparison of events where the respondents reported a change in attitude towards the provider instead of a behavioural reaction indicated that, for clinic clients, negative stereotyping overwhelmingly resulted in feelings of embarrassment and hopelessness and compounded their beliefs about themselves as being ‘just a junkie’ and providers ‘using their power’ against clients. All community based clients who did not take action against stereotyping based their decision on restrictions regarding the number of available alternative treatments, as the following example shows:

And I’ve found the service at the chemist at [another town in the program] was excellent—lovely people and no hassles, whereas here you’re just categorised. You’re not sort of looked upon as just another customer in a chemist shop; you’re one of
‘them’. And we all get on well, but they believe they have the right to treat you really shabbily. Like, there was one time at the chemist there where I’d been working long days, I’d fallen asleep at night and woke up early. I’d fallen asleep on the lounge, cooked tea, didn’t eat it, fell asleep, got up in the morning, went to work early and then raced into the chemist at 9 o’clock to get my dose and he had a go at me about the way that I was dressed and my appearance. And I was really offended by it. I’d been to work. I was looking rough. My hair was all over the place and it was like I hadn’t had a shave for a few days, and he just had a shot at me. Remember that, [partner]?

A. Yes.

Q. Do you remember what he said?

B. Like, he didn’t want to serve me if I didn’t take a bit of pride in my appearance.

A. He told you to dress—don’t come in tomorrow wearing—in that state.

B. Yeah, ‘Take a bit of pride in yourself’, and I thought it was really irrelevant. But I mean, if you say anything, if you bark up, he’s the sort of fella that will just say, ‘If you don’t like it, go to the hospital.’ So he plays a power trip.

A. Very much so.

B. He’s worse than some of the drug dealers that you have to deal with that play a power game because they’ve got the goods. They know you want it, so they’ll have you dancing for them, you know. And it’s really funny, but it’s exactly the same thing as the illegal dealer, you know.

Q. It’s interesting. A few people—the couple of people that I’ve already interviewed in the area have mentioned this experience as well. It was interesting that one woman, for example, had a jumper tied around her waist and he wouldn’t serve her until she took it off because it didn’t look right.

A. Yeah. Now if that was anybody else...

B. ...who came in for a script...

A. I’m sure that he wouldn’t say anything. He wouldn’t even notice it. (Community clients)

The respondents, more commonly community clients, described 21 events where they experienced an improvement in their attitude towards treatment staff based on a disconfirmation of their expectation of negative stereotyping, which was acquired as a result of prior treatment experiences. Clinic clients in particular indicated that a lack of judgment towards them based on their social status made them ‘feel very comfortable’ with the provider and feel better about themselves. Positive events nominated by the respondents appeared to relate equally to the case worker, dispenser and prescriber.

*Exposure:* The study participants described 35 situations where providers engaged in activities that provided public evidence of clients’ treatment status and which contributed to common negative stereotypes of clients in that treatment category. The most commonly cited instances of client exposure related overwhelmingly to
community dispensers and were based on clients being served in view of other customers; being served after other pharmacy customers regardless of their arrival time; being made to wait up to 30 minutes to be dosed; and being given notice of overdue accounts in front of other customers. Most of the experiences were provided by community clients. Of these, 19 were expressions of dissatisfaction that resulted in four clients returning to dose at the clinic. Seven of the eight instances of dissatisfaction with public exposure provided by current clinic clients were from those with a diagnosis of paranoid personality disorder. Of the community clients who reported dissatisfaction, three complained to the chemist about the problem but achieved no resolution of the issue and the remaining five reported developing strategies to avoid being recognised by other customers in the pharmacy, such as pretending to be buying other items, temporarily leaving the store or choosing to dose at times when the least number of customers was known to be present. Those clients who reported negative attitudinal outcomes on the topic of exposure were also mostly community clients. They described fears about the effect on their relationships in a small place once others learnt of their social identity as a ‘second-class citizen’. However, they reported being ‘stuck’ in taking action because there were ‘no alternatives’ for treatment. The following description from a respondent who returned to clinic dosing highlights how community clients learn that the common expectation of being served in order of attendance at the pharmacy does not apply to them:

A. It’s horrible. It’s a pain. Actually, customers would actually say to [pharmacist], ‘She’s been here. She’s waiting’, and [pharmacist] would say, ‘She’s right’, when I wasn’t. I had to get to work earlier. I didn’t abuse him or anything because he’d throw you out. Then he’d come back and apologise and say, ‘Sorry’, blah, blah, blah, but, you know, you could see he was serving other customers before me.
Q. So even though he apologised, he didn’t stop doing it?
A. No.
Q. Did he give a reason when he apologised?
A. He did say, ‘Today was a busy today. I had to get these scripts out.’ He would be filling a script when I would walk in there, which is fair enough. But a lady come in and asked for cold tablets and he’d go off to the other end of the chemist and would talk about that when he should have served me next. (Clinic client)

By contrast, seven positive surprises were reported by the respondents with regard to three dispensers dosing them in private and serving them in order, particularly
when they had not experienced this in other regions of the program. One clinic respondent favourably compared the dispensing practices of clinic staff with their counterparts in the jail system, finding that the less obvious use of power and control by clinic staff resulted in fewer personal public reminders of his treatment status and an increase in his self-esteem.

Exchanges of Services

Dosing time: The study participants discussed 42 events involving the amount of time available to dose either at the clinic or in pharmacies as a result of the opening hours of the site or the time required to administer buprenorphine. The majority of experiences relating to dosing time were negative, and most were registered by clinic clients, who reported dissatisfaction on nine occasions and disappointment on 24. The respondents were overwhelmingly dissatisfied with the limited once-daily opening hours of the clinic dosary because of its disruption to their employment and complained to the clinic manager or staff on this basis. For some, the difficulties imposed by juggling work demands and attending at the clinic during dosing times were found have moral consequences, as the following example shows:

But I’ll still be stuck on this methadone. That doesn’t bother me so much. But it needs to be a bit more flexible. That’s why it’s not working for me. To try to be a furniture removalist, you know, like, it’s a bit hard to try and stay local all the time because there are times they’ll say, ‘Look, the other bloke can’t make it’ or whatever, you know. Because I’ve got a licence, ‘We haven’t got another driver. You’re it.’ And I say, ‘Oh, me mum’s sick.’ But then I’m lying, you see, and I was trying to get away from all that, you know. (Clinic client)

Clinic clients who reported negative attitudinal reactions regarding the issue of dosing time partly did so also in respect of the limited clinic opening times. However, half of the instances where clinic clients reported disappointment with dosing time concerned delays experienced as a result of buprenorphine administration. Almost all clients reported that there should be separate dosing queues for methadone and buprenorphine clients because of this problem. Five study participants from the clinic who reported positive attitudes regarding dosing time did so in respect of pharmacy dosing or considered current clinic dosing by comparison with their experience on
Client Satisfaction with Opioid Replacement Treatment

By contrast, most of the 13 positive experiences on this topic were provided by community clients, who valued the flexibility in dosing time provided by pharmacy opening hours. In most of these cases, the source of the respondents’ positive attitude was past experiences of clinic dosing or other community pharmacists who adhered to fixed dosing schedules. One community client who registered dissatisfaction with dosing time did so with regard to the limited hours available for hospital dosing, as a consequence of which she moved to dose at the local pharmacy. Four instances of negative attitudes regarding dosing time from community clients generally concerned the waiting time to dose at the pharmacy. In these cases, the respondents did not interpret the time taken to be served as evidence of the pharmacist’s discriminatory attitudes but merely reported it as the inconvenience it was.

Physical facility: The respondents provided 24 examples of issues related to the accessibility of the dosing site and its layout such that it either promoted or inhibited client interaction and safety. Fourteen of these were negative, and all were provided by clinic clients. In 11 instances, the respondents reported that they were disappointed by the inconvenience of the dosing site in relation to public transport, the appearance of police near the clinic and encounters with aggressive clients, some of whom would ‘stand over’ others to jump ahead in the queue. In the three remaining cases, the respondents reported dissatisfaction on these issues, which they dealt with by moving to another part of the program, seeking advice from their case worker and arriving at the start of the dosing period to avoid other clients. All eight cases of negative experiences related to intimidation from aggressive clients, including the three cases of dissatisfaction, were reported by women. One woman described the problem as a symptom of the restricted dosing times:

Just half the people—that’s one reason why I come early, so I don’t have to run into half the dickheads. Because there’s always an argument. There’s always an argument. I told the [dispensing staff] to go to the deli and get a ticket thing so when we walk in, we all take a bloody ticket and no-one can argue over shit. They said, ‘You can’t do that.’ I
said, 'Well, you should do something because people are pushing in.' People come in
and wait, and because they're waiting for the bupe, they'll go out and have a quick puff
and whatever. Someone else will walk in, and that's how the drama starts. 'We were at
the door first', 'You were outside, so you wait in line' sort of thing. You always get
your dramas; you can't—you can't stop your dramas. But if there was more opening
time, then there wouldn't be so many here at the one time, do you know what I mean? It
would be more spread out, yeah. (Clinic client)

There were 10 events where the study participants positively evaluated the
physical layout of the dosing site and reported a change in attitude after discovering the
facility was safer than they had expected. Five examples were provided by clinic clients,
who reported that the locked rooms in which they individually received their dose under
the supervision of dispensing staff increased their sense of safety and that the option of
dosing at a comfortable private facility not associated with a hospital or with a large
number of clientele preserved their sense of privacy. The remaining five evaluations
were provided by community clients, who indicated that dosing at a pharmacy rather
than a clinic was geographically more convenient and enabled them to better avoid
other program clients.

Rules: The respondents discussed 40 events relating to program rules for
takeaway allowances, dosing intoxicated clients, consultation with case workers,
transfers and urine testing. Thirty-two of these were negative, including nine
expressions of dissatisfaction, and most were provided by community clients.
Respondents from the community sector provided 11 examples of disappointment
relating to the limited number of weekly takeaway doses available. Many noted
discrepancies in the size of the allowance offered in interstate programs and indicated
that those with a 'good record' of using takeaways responsibly should be entitled to
more than the maximum of four per week. Most community clients who discussed the
issue adjusted their expectation to fit the circumstances by recognising that some clients
would abuse the privilege and that it was better to have some takeaway doses rather
than none at all, as occurs at the clinic and hospitals. Accordingly, the absence of
takeaway availability at the clinic was also raised twice by clinic clients. The remaining
sources of disappointment for both clinic and community clients on this issue was the
need for compulsory reviews with case workers. The respondents unanimously agreed
that such meetings were ‘unnecessary’ when their treatment and life generally were ‘stable’.

Of the nine expressions of dissatisfaction regarding program rules, six were provided by community clients, who complained to their prescriber after being denied takeaways for missed doses or who felt restricted in undertaking employment because of their limited availability. One long-term client cut off the program despite forewarning the pharmacist that he would have to miss dosing because of work commitments felt that the provider concerned, a pharmacist, should have exercised discretion in applying the program rules:

B. Back to that—when I was working away, yeah, the end result was I came back and [the pharmacist] cut me off.
Q. He cut you off?
B. {laughs} Yeah. He wouldn’t dose me.
A. That’s right.
B. He wouldn’t dose me, so I rung me doctor up and my doctor faxed down another script to sort of start me off again or whatever. But it was unnecessary. I mean, he has got—he’s got the right to make his own decision. He’s got a bit of weight there where he can take it upon himself to say, without breaking the rules, ‘Oh, well, [client] did ring me and let me know that he wasn’t going to be back in time because he was away working’, and they would have worn it if someone had come down on him about breaking the rules. He would be covered, I’m sure, you know. (Community client)

One clinic client, who formerly dosed in the community, also complained to the prescriber after having takeaway privileges temporarily removed on suspicion of her injecting them. The remaining clients complained to program staff about the need for compulsory case reviews.

Eight instances of unexpected pleasant experiences regarding program rules were reported by community clients. In two cases, these related to the ability to access takeaways per se and were identified by comparison with the client’s prior need to undertake daily hospital dosing. The remainder concerned the capacity of pharmacists to alter days to collect takeaways and consistency among programs with regard to allocating takeaway privileges to individuals.
Program access: The study participants provided 14 examples of issues regarding waiting time to gain access to the program and the rules regarding admission. Twelve of these were negative. All of these clients appeared to be disappointed by the length of time taken to join the program, which was reported as two to three weeks on average. However, community clients tended to express disappointment while clinic clients tended to show dissatisfaction, most notably in the form of lying about the extent of their opioid dependence in order to provide an increased perception of treatment need. For many respondents, including the following client, the source of the problem was insufficient screening, whereby those who did not have a ‘legitimate’ heroin addiction were taking up places that were the preserve of those who were ‘serious’ about confronting their problem:

I was surprised—well, I am surprised how easy it is for people to get on the methadone now. Like, for me, it was pretty easy, but I’ve heard stories off other people: it’s like methadone was your last resort or you’d be looking at jail or things like that and then they’d put you on the methadone. But now you can just go up there and—I know speed freaks that are up there on the methadone and it’s just unreal.

Q. Yeah. What do you think about that, the fact that it is sort of so easy to get on?
A. Well, I don’t know. I suppose it’s good—it’s good if you’re an addict, you know. But if you’re just going up there to get methadone to get out of it, you know what I mean, like that, it’s not that good that way. But if you’re an addict, it’s good that you can get on it so quick and that.

Q. But then it leaves it open for a bit of abuse?
A. Yeah, it does. It does, yeah, yeah. And, yeah, there’s not really much of a screening process. Well, when I got on it, there wasn’t. (Community client)

Two respondents who expressed positive attitudes regarding program access did so because their expectation for prompt admission to the program was met. One received immediate entry because of her pregnancy while the other considered a delay of two to three weeks until admission to be reasonable.

Consultation: The respondents discussed 52 events related to the capacity of providers, mostly case workers, to be accessible, responsive to client requests and flexible in implementing program rules. Thirty-two were positive evaluations that resulted in improved attitudes on the part of the respondents, and they were provided in roughly equal number by both clinic and community clients. The vast majority of these
participants indicated that they appreciated the ease and speed with which case workers were able to organise, and resolve problems with, temporary transfers, counselling and appointments for script renewals. In 11 instances, the respondents registered surprise with the level of service provided simply because they had not received it in other programs or from other providers. Clinic clients tended to report feeling ‘positive’ and better about themselves when providers were responsive while community clients reported having a more positive attitude towards the particular individual concerned. One clinic client who found an improvement in his relationship with program staff as a result of their responsiveness described it in the following way:

If you asked [staff for information] in [interstate program], they’d just throw it off. If you ask them here, they find out for you. They’ll ring straight upstairs. [The dispensing nurse] will ring upstairs straightaway, and if she can’t get any answers, she’ll let you know tomorrow, you know, things like that. It’s good, very good.

Q. Okay.
A. Whereas in [interstate program], it’s, ‘Oh, I don’t remember you asking me that’, you know, which is just bullshit, yeah. It’s a lot better place.
Q. Okay. And so does that change the way you feel about this place at all?
A. Oh, the women, yeah.
Q. Yeah?
A. Like, I go in and have a bit of a joke with them and talk to them, you know, and they’re quite good, yeah. (Clinic client)

Twenty negative evaluations of providers were also provided in almost equal number by community and clinic clients, with five of these being expressions of dissatisfaction. The respondents indicated disappointment with the inconsistency in speed with which transfers could be organised, where case workers could process the paperwork quickly ‘in an emergency’ yet not all the time. Others reported that the limited availability of the prescriber for script adjustments and the case workers for counselling failed to meet their service expectations. Clinic clients felt more hopeless than community clients because of this. Three clinic and community clients who registered dissatisfaction with accessing temporary transfers, in part because of the limited availability of the prescriber, indicated that they temporarily resumed or increased their illicit drug use to deal with the problem while another complained to a regulatory body to expedite a resolution of the issue.
Exchanges of Information

The respondents discussed 15 issues related to the perceived knowledge and competence of the providers in treating drug dependency acquired through either education or experience. Ten examples of positive attitudes regarding the competence of the prescribers and case workers were provided in equal number by clinic and community clients. In almost all cases, the respondents were surprised and 'reassured' by how 'shrewd' these program staff were in knowing when clients 'would buckle' and relapse to heroin use, particularly by comparison with providers in other treatment programs. Most study participants indicated that they were therefore happy to be guided by their advice.

On four occasions, three of which were provided by clinic clients, the respondents provided negative assessments of prescribers, mainly as a result of comparisons with other providers. In particular, they were disappointed at the prescriber's lack of knowledge about either the side effects of buprenorphine or how to respond to client relapses. One client expressed dissatisfaction on this issue, and this concerned the prescriber's failure to consider the client's level of understanding of his health condition. As can be seen, while the respondent addressed the problem by simply ignoring the prescriber's direction, the incident firmly established his perception of the prescriber as someone whose knowledge is flawed:

Q. Do you want to tell me about your experience with [prescriber]?
B. Oh, he's—the only problem I have with him is he thinks he's a know-all. He really does. And he tries to tell you what he thinks is better for you when you know what he's saying isn't true. And you try to tell him you're different and he won't listen to you. He just cuts you off. That's what I don't like about it.
Q. Have you got an example of that?
B. No. Well, he'll be telling me how I should be getting on the—like a sedative.
A. Oh, there's a tablet now apparently you can get.
Q. Buprenorphine?
A. Yeah, that's it, yeah.
B. No, not that. This one is for—it's like an antidepressant. Prozac. He's trying to get me to go on that, and it doesn't work for me. I've told him that. He said, 'Yeah, but you don't give it a chance. You've got to give it at least four to six weeks.' And I just told him I was on it for 45 months and it didn't make no difference and I didn't like it.
He insisted. He got out a script and insisted that I took it. And I didn’t bother getting it. But shit like that, you know. (Community client)

Exchanges of Goods

Drug: The respondents supplied 45 evaluations regarding the side effects of the pharmacotherapy or their responses to withdrawing from it. Of the 24 negative responses to either methadone or buprenorphine, there were six expressions of dissatisfaction, wherein both clinic and community clients started dosing with buprenorphine because of nausea, lethargy and concerns about withdrawal from the use of methadone. Most of these clients indicated that they expected to complete treatment within the next three to six months. Approximately half of the 18 respondents who reported disappointment with methadone expressed an interest in trying buprenorphine but had baulked at realising this interest because of either insufficient knowledge about its effectiveness and side effects or they were currently on too high a dose of methadone. Prospective recipients cited the attractiveness of alternate day dosing, the chance to ‘have a clearer head’ and the ease of withdrawing completely from the drug as inducements to dose with buprenorphine. However, such comments were sometimes counterbalanced by the following types of concerns:

But there again, I’m looking at the bupe in the long run. I’m not real sure about it. I don’t know about it. But I’m not looking at it now at all, no way. Just wouldn’t work at the moment for me. I’d rather know—better the poison I know, if you know what I mean. I know this one and if I do stuff up, I’m not going to go into instant withdrawals or anything like that, you know. Like, oh, boy, because I wouldn’t want to go through that either again. That’s probably why I went back on the methadone. Yeah, but um, yeah, I don’t know. I just take it as it comes, I think. I haven’t made any sort of decisions on it yet. It’s still too early for me. It hasn’t been long.

Q. Are they trying to encourage you to go to the bupe?
A. Yeah, they are, really. But I—I haven’t heard all good about it. I have heard a lot of good, and I think it’s good that there is another option. But, yeah, I think they need to let you know a bit more about it, you know what I mean? Yeah, I think because it’s fairly new still too, I’d like to know just a little bit more about it before I go doing anything like that. Like, I’d like to know how is it on your liver, you know, little things like that. Like, my liver is probably stuffed. I’m pretty sure it is stuffed. I know I go through hell with it at times, so I’d like to know how it’s going to work on my liver. I also heard that if you do have any accidents or anything like that, there’s no painkiller that gets over it, you know, things like that. Now we’re getting old. This is the time in
life that our bodies do start to break down and things like that, so *you've* got to think very seriously about things like that too. So, yeah. (Clinic client)

The 21 positive reports regarding the pharmacotherapy were supplied in roughly equal number by clinic and community clients. In all but one case they referred to methadone and its capacity to reduce opiate cravings, mitigate the effects of depression and assist in stabilising the respondents' life by reducing their reliance on crime. Seven study participants identified positive behavioural outcomes as a result of their use of methadone, being predominantly the acquisition of employment but also an improvement in their close relationships.

**Drug level:** The respondents provided 18 events regarding the ease or otherwise of identifying, setting and maintaining an effective dose of the pharmacotherapy as well as accessing psychotropic medication from other prescribers once use of the opioid substitute is discovered. Twelve of these were negative, including five expressions of dissatisfaction, almost all of which were offered by clinic clients. In two cases, the respondents reported dissatisfaction with the need to consult the program prescriber before increasing their dose of the pharmacotherapy, in response to which they returned to illicit drug use until their next script renewal appointment. In the remaining cases, the respondents complained to the manager of the program and the relevant providers about the program rules requiring reduced doses for two consecutive missed dosing appointments, perceived inconsistencies in the strength of the dose dispensed at the counter and an inability to acquire a script for a barbiturate.

Seven cases of disappointment with the issue of dose setting and maintenance covered a range of issues. These included: the slowness with which clients were required to reduce their dose when attempting withdrawal; the ability of the dispenser to reduce the dose permitted on the script because of missed appointments by the client; program rules requiring daily dosing of methadone; a lack of guidance by providers regarding treatment dose planning; and perceived inconsistencies in the strength of the dispensed dose. In considering these topics, most clients harboured suspicion regarding the motives of staff, some considering that more favoured clients of the provider would not receive the same treatment or that maintaining clients in treatment on stable doses
ensured ongoing employment for the provider. For others, such as the following couple, alterations to the script instituted by the dispensers simply created confusion:

B. The thing is they override—the nurses and that were overriding what the doctor wrote down. He wrote three takeaways that she could have them no problem, and the staff here either said no or someone said that you couldn’t get it.
Q. And this was to dose somewhere, like, out in the bush?
B. Yeah.
Q. How can that happen? I mean, how can these guys—
B. Don’t know.
A. We don’t know.
B. That’s what we ask too.
A. They’re just nurses and, like, they’re counsellors, so I don’t know how they can override it. And even the pharmacist, he should be—if a doctor writes out a script for anything else, it’s done to the letter. And all of a sudden, what, it’s different because it’s methadone?
B. Because there’s discretion? (Clinic clients)

The respondents provided six accounts regarding dose levels that resulted in unexpected positive changes in their attitudes on the topic. In five cases, the respondents indicated that they valued the fact that their prescriber was ‘flexible’, responsive and did not ‘follow a formula’ in assisting them to find a therapeutic dose.

Exchanges of Money

Treatment cost: The respondents discussed 29 incidents related to the cost of dispensing the pharmacotherapy. Nineteen of these were negative, including seven indications of dissatisfaction. Five clinic clients, all unemployed at the time of interview, had returned to the clinic because of their inability to meet the expense of dosing at the local pharmacy. Two community clients who expressed dissatisfaction with the cost of treatment and were also unemployed at interview indicated that they complained to the pharmacist about the problem, used illicit opiates or sacrificed expenditure on other personal items to fund their treatment.

Of those who expressed negative attitudes regarding the cost of treatment, community respondents indicated that they were considering returning to the clinic while clinic clients indicated that they had no intention of moving to the pharmacy because of the expense of treatment. Some community clients indicated that they
tolerated the expense of pharmacy dosing in light of the benefits it held over clinic dosing, particularly with regard to dosing hours. Most clients considered it fair to make a contribution to the cost of their treatment. However, it was the expected level of that contribution which was problematic, as the following example illustrates:

And I know it’s all red tape bureaucratic rubbish that prices it. But all the S8 drugs—the MS Contins and Oxycontins, all those—it was just a matter of finding $3.70, and a script would last for 10 days. But now it’s $30 a week and $60 a fortnight. And it’s basically—to me, it’s the same drug; it is an S8 opiate. I don’t understand why, you know, people can get the Oxycontins and the MS Contins and most people who are prescribed that are injured, they’re on a pension, or they’re retired, old people with problems. And if they are injury people, they’ve usually received large payouts. If they are retired, they’ve usually got their super. You know, they’re people with money that are getting the $3.70 things. And most people who are on methadone are unemployed and battling and yet they’ve got to pay $60 out of every cheque. If you’re only getting $360 a fortnight, that’s a big piece out of it, you know. That’s the only gripe I have with it. I manage. I manage it, but I could do—like, my fridge is pretty empty. It would be a lot better spent here than there. But, no, I understand that things do cost, but I don’t think they cost that much. (Community client)

There were 10 examples of positive attitudes from the respondents with regard to treatment costs, four from clinic clients and six from community clients. Perhaps unsurprisingly, all clinic clients discussed the personal value of having access to a free clinic service, particularly in comparison with a nearby interstate fee-for-service clinic program. While not all of these clients were recipients of government income support payments at the time of interview, most considered the issue in terms of the difficulty of attempting to meet ongoing dispensing costs when on a low income. Community clients who considered the cost of treatment reasonable did so by comparing it with the higher dispensing fees charged in interstate programs in major metropolitan cities and comparing it with the cost of sustaining illicit drug use. Clients more resigned to the situation considered dispensing fees ‘just another bill you have to pay’.

**Late payment:** The respondents discussed five instances regarding their pharmacist’s arrangements for providing credit to clients who do not meet the upfront dispensing fee. Two clinic clients reported dissatisfaction on this issue and indicated that they ended up leaving the chemist because of the humiliation of being reminded
about their arrears each time they went to receive a dose. One client described the problem in the following way:

I’d been down there [at the pharmacy] I think three years. I hadn’t been behind. This one time I got behind $50 and every time I went in there I felt rotten and [the pharmacist] reminded me about the money. I tried telling him, you know, ‘You’ll get it’, and I paid, but I felt rotten. So I come back [to the clinic].
Q. So what sort of things did he say?
A. Well as soon as he’d bring me methadone out, he’d look at the card—he made a point of looking at it—and saw ‘not paid’, ‘paid’, ‘paid’, ‘paid’. Then he’d probably cross it out a bit and every time remind you, ‘You’re behind, and can you pay?’ And in the end you’d dread if he was there. Like, he was the only one who’d pull me up. (Clinic client)

Conversely, three positive evaluations provided by community clients concerned pharmacists providing a line of credit ‘once in a while’ in extenuating circumstances. These respondents reported that clients should pay on time and were surprised at how ‘kind’ it was of the pharmacist to unexpectedly extend them credit on these occasions.

The Development of the Final Model

The final results are presented according to the elements of the proposed model of client satisfaction and are described separately for the process and content dimensions of treatment. In principle, themes recorded against the particularistic, or relationship-specific, resources of love, status and services are used to identify client expectations about, and responses to, the process or manner of treatment delivery by providers while themes identified with the less particularistic resources of goods, information and money are grouped to show client evaluations of specific components of the treatment. However, given that the boundaries between neighbouring items in the circumplex of the resource classes is permeable (see Figure 3.4), the resources of status, services, goods and information may contain themes that involve both more and less particularistic items. The data obtained in this study were found to reflect this point. For example, the resource category of services contained the particularistic item of ‘consultation’ as well as the less particularistic items regarding dosing time, program rules, program access and the physical facility. Similarly, the findings regarding the resource of information appeared to relate to the respondents’ perception of the
providers' knowledge, not the less particularistic issue of information they acquired simply through being on the program. As such, these individual particularistic items are presented as part of the processes of treatment while the non-particularistic items associated with the resource of services were grouped with the content of treatment.

In identifying the elements of the proposed satisfaction model, the primary focus will be on those events or features of the program that tend to elicit client dissatisfaction. These are the critical components of care as they are associated with negative behavioural responses from clients. Therefore, the aim of this section is to identify the normative expectations clients have that establish the boundaries of their tolerance for variation in treatment practices as well as to identify the conditions under which they are more likely to be breached. These conditions include aspects of the clients' profile or structural features of the program that produce variation in the forms of treatment received by different groups of clients.

A secondary focus of this section will be the effect on clients of treatment events found to be satisfactory. In particular, the aim of this section is to identify whether particular types of treatment events are of benefit to clients with particular profiles or who are in different sections of the program. The predictive expectations clients have about these events—that is, what they anticipate is likely to happen—will also be highlighted.

*Client dissatisfaction with treatment processes:* Figure 8.1 shows the kind of reactions dissatisfied clinic and community clients display when their normative expectations regarding the providers' handling of relational issues involving love, status, services and information are breached. For dispensers, being either the clinic nurses or community pharmacists, client dissatisfaction is more likely to arise over issues of status. For case workers and prescribers, dissatisfaction is typically registered over issues of love, service and information.
The above figure shows that, for issues involving love, clients react negatively to the treatment relationship when providers fail to demonstrate an acceptance of, and respect for, the worth of the client’s perspective. As such, the minimum normative expectation among clients seems to be that providers will tolerate, or have an attitude of...
Client Satisfaction with Opioid Replacement Treatment

neutrality toward, differences in the personal experiences of the provider and client. Moreover, clients expect that the worth of their personal perspective will be preserved and not intruded upon by either providers directly or others indirectly through the actions of the provider. Clients who perceive an absence of respect from, or acceptance by, providers react differently depending on which part of the program they receive treatment in. Clinic clients, particularly those who continue to use illicit drugs while in treatment, are more likely to withdraw from the treatment relationship and transfer to another part of the program. Clinic clients not otherwise engaged in illicit drug use may also experience relapse in such circumstances. On the other hand, community clients are in the first instance more likely to try to address the issue with another treatment provider before withdrawing from the affected relationship.

Figure 8.1 indicates that critical events involving status likely to invoke negative client responses to the treatment relationship concern the providers’ insensitivity to, and implicit support of, the use of negative social stereotypes regarding illicit drug users. This suggests clients have a normative expectation that drug rehabilitation programs will involve relationships with treatment staff that are free of the usual stigma attached to illicit drug users found in the general community. When this expectation is breached, both community and clinic clients are negatively affected. However, clinic clients, particularly those with paranoid personality traits, are likely to show more personally disruptive responses such as withdrawing from the treatment relationship or moving elsewhere on the program. Community based clients are more likely to either complain to the provider or develop ad hoc strategies to adapt to the exigencies of the situation.

While incidents involving the way program staff relay information or supply services to clients in and of themselves did not produce client dissatisfaction in this study, their level of availability to do so did. This suggests that, at a minimum, clients expect treatment providers to be readily accessible to them. Clients more likely to report dissatisfaction because of breaches of this norm are based in the community sector, where contact with providers is generally more limited than for clinic clients. In response to limited provider contact, community clients are likely to complain to either
the individual concerned or an allied authority or develop an incidental solution tailored to the nature of the problem.

*Client dissatisfaction with the content of treatment.* Figure 8.2 shows the components of treatment with which clients are likely to express dissatisfaction. In short, these involve the provision of goods and services and the means by which they are financed. The issue most likely to invite a negative response from clients with regard to goods is the effectiveness and safety of the pharmacotherapy itself. This appears to be because clients have a normative expectation that the side effects of the medication will be tolerable, particularly when reducing from the drug. When this is not the case, clients are likely to transfer to an alternative pharmacotherapy which they believe has fewer side effects, particularly if their treatment goal is to complete treatment within the coming six months. Given that at the time of this study buprenorphine dosing was in its infancy in the program, the clients who transferred from methadone tended to be based at the clinic.

The data from this study indicates that a number of elements regarding the structure of service provision in the program are likely to arouse client dissatisfaction. However, these vary according to the section of the program in which clients are based. Clinic clients are likely to experience difficulties with the timing of treatment, its overall accessibility and its safe delivery while community clients are more likely to have problems with the rules regarding the provision of takeaway doses. As Figure 8.2 shows, clinic clients expect to have more than one fixed daily period in which to obtain their dose and are likely to complain to the providers—namely, the dispenser or clinic manager—about the issue. If clients report dissatisfaction with gaining access to the program, it is most likely due to an expectation that treatment applicants be granted admission to the program at the time of applying or as soon as possible thereafter. Clinic clients are most likely to react to delays in gaining entry to the program by lying about the extent of their problem. Dissatisfaction with the protection of client safety is most likely to be reported by female clinic clients on the basis of a general expectation that all clients will be free from intimidation by others, including the police and other clients, when collecting their dose from the clinic. Women who report difficulties with
threats of intimidation are likely to complain to a staff member while those who encounter acts of aggression are more likely to transfer elsewhere. Community clients are most likely to report dissatisfaction with the application of the policy on takeaway doses. In particular, clients expect that rules specifying the maximum number of weekly takeaway doses be applied consistently across and within programs and that takeaway privileges be awarded on the basis of the client's record of good behaviour on the program. When this does not occur, clients are likely to complain to staff.

The final aspect of treatment where clients may report dissatisfaction is its cost. This is shown in Figure 8.2 under the resource of money. While most clients in this study indicated that they expected to contribute towards the cost of their treatment, it was on the basis of a normative expectation that the treatment would continue to remain affordable for those on the program with the least capacity to pay—namely, clients dependent on some form of government welfare. Accordingly, clients most likely to register dissatisfaction with the cost of treatment are community clients receiving some form of income support payments, such as the unemployment benefit, the disability support pension or sole parenting payment. When the cost of treatment becomes prohibitive, these clients are likely to transfer to the free clinic or hospital dosing service.
GOODS
Regular provision of an effective, safe pharmacotherapy

SERVICES
Provision of safe, accessible, timely treatment delivered in a consistent way

MONEY
Provision of cost effective treatment

That there be two daily dosing periods

That clients be free from intimidation

That takeaway privileges be consistent

That entry to the program occur at application

Complete in 3-6mths

Clinic dosing

Community dosing

Female

Income support

Change pharmacotherapy

Lie about problem

Complain to provider

Transfer elsewhere

Figure 8.2 The effects of client dissatisfaction with specific treatment components.
Client satisfaction with treatment processes. Figure 8.3 shows three main areas of treatment delivery where, given the presence of certain factors, clients are likely to report satisfaction based on positive changes in their attitude and behaviour towards themselves as well as the treatment providers. With regard to issues of love, the data in this study indicates that when providers act authentically and show goodwill and warmth to clients, these factors, in addition to demonstrations of acceptance and respect, have a positive impact on all clients. While clients believe that program staff are likely to be warm, respectful and accepting in working with clients, their experience of other programs lend them to think the probability of staff being sincere or showing goodwill is low. Clients who report satisfaction in this domain report the nature of the impact differently according to the area of the program they are in. Clinic clients, and particularly those with a paranoid personality style, in the first instance tend to feel better about themselves and be more hopeful about their prognosis in treatment. Clients who have relationships with providers who supply these forms of platonic love may also be able to better tolerate these providers’ refusal of requests for assistance. Improvements in these clients’ sense of wellbeing has an influence on improving their attitude towards the provider. Community clients, on the other hand, tend to simply report improvements in their relationship with the provider, which manifests in increased honesty and greater contact.
Figure 8.3 The effects of client satisfaction with the process of treatment delivery.

Figure 8.3 shows a somewhat similar pattern of results for issues regarding status. When providers communicate to clients that they will not reinforce community stereotypes of illicit drug users either through their comments or the way they structure their work practices, clinic clients tend to report an improvement in their self-esteem while community clients appear to report an improvement in their attitude to the provider. These outcomes are based on a disconfirmation of clients' negative prediction of discriminatory attitudes on the part of providers. Finally, both types of clients are equally likely to report satisfaction with the competence of providers and the flexibility
and responsiveness with which they deliver services. However, once again, community clients are likely to register positive changes in their attitudes and behaviour towards the program while clinic clients initially recognise improvements in their feelings about themselves. These improvements in perception result from clients’ probabilistic expectation of low standards of care by staff that were established through experience with other programs.

*Client satisfaction with the content of treatment.* Figure 8.4 shows the effect of client satisfaction with specific components of treatment. As can be seen, three areas of treatment covered by the resource classes of goods, services and money impact on community and clinic clients, though in somewhat different ways. When clients find the pharmacotherapy to be effective, as they predict it will be, they are likely to notice a reduction in their craving for other drugs and an improvement in their quality of life. Clinic clients who find the current location and structure of the dosing environment unexpectedly protects them from aggressive clients are likely to report that their privacy has been protected and that they feel safe. On the other hand, community clients who find the structure of the treatment favourable are likely to do so because of the geographical convenience of pharmacies and the flexible dosing hours they offer. Their satisfaction is usually based on their predicted expectation regarding these aspects of the treatment having been met. Finally, clinic clients who report satisfaction with the cost of treatment do so in the knowledge that their clinic is one of the last few free opiate substitution programs in the region. Community clients who consider the treatment cost effective are likely to do so by comparison with their former illicit drug use. In both cases, clients have anticipated that the cost of their care will be affordable for them.
The general aim of the current chapter was to identify the areas of the SAHS opioid replacement treatment program evaluated by clients as either satisfactory or unsatisfactory, to identify the bases of these evaluations and to describe their impact both for the clients and the program. This was achieved, firstly, by isolating the normative and predictive expectations which the proposed theoretical model suggests are the means by which clients evaluate their treatment experiences and which form the

**Discussion**

The effects of client satisfaction with specific treatment components.
foundation for their responses. Secondly, the conditions under which these expectations would be activated, such as features of the client or the part of the program under which they receive care, were identified. Thirdly, the effect of unmet expectations on the clients' response to these significant treatment events was examined in relation to themselves and their involvement with either service providers or the program generally. Aspects of treatment nominated as significant were categorised according to a resource type so that any differences in client responses to the process and content dimensions of the treatment environment could be established.

Considered overall, the tabulated frequencies indicate that clinic clients identified more negative than positive treatment experiences than community clients. In particular, clinic clients reported a greater number of negative behavioural reactions to the program, which suggests they are more dissatisfied with treatment than community clients. For both client groups, issues associated with the resources of love and services were most frequently reported. However, clinic clients reported more dissatisfaction with the provision of services than community clients. Given their greater level of contact with, and supervision in, the program, it is unsurprising that problems with access, dosing times and the physical layout of the treatment environment are more likely to arise for these clients. While clinic clients registered fewer instances of dissatisfaction with issues of love than community clients, an examination of the qualitative data indicates that their reactions to unsatisfactory events involving the resource of love had a more negative impact on their self and relationship to the program than for community clients. Together, these results indicate that clinic clients have a generally narrower zone of tolerance for unmet expectations regarding treatment.

For both clinic and community clients, the overwhelming majority reported attitudinal reactions to treatment, which indicates that they tended to assimilate any unmet expectations with their experiences. Where clients experienced a discrepancy between their prediction of what would happen and the event itself, the probabilistic expectation was most commonly based on a contrasting experience in the recent past. For community clients, probabilistic expectations were also assimilated when there seemed no viable or practical alternative to the issue. In theoretical terms, this process
of attitudinal accommodation would have resulted in most clients ultimately regarding their experiences as satisfactory. Considered in this way, the results are consistent with those of the quantitative satisfaction measure employed in Chapter 7, which found that both groups of clients rated the global quality of the treatment environment positively.

With regard to the domains of treatment, almost half of the respondent evaluations identified as important related to the manner in which treatment was delivered by providers. Most experiences involving prescribers were rated positively while most events involving dispensers, which overwhelmingly concerned pharmacists, were rated negatively. Only marginally more positively than negatively valenced events were provided regarding case workers. While resource exchange theory suggests treatment processes would be best represented by the particularistic resource categories of love, status and services, the findings in this study indicate that, based on client evaluations, issues related to the resource category of information were also particularistic in nature.

Respondent evaluations related to love indicated that one of the minimum normative standards by which clients consider the delivery of care to be satisfactory concerns their receipt of acceptance and respect from treatment staff. When staff cannot tolerate aspects of clients that define them as individuals or preserve the right of clients to be privately self-directing, both clinic and community clients are likely to express dissatisfaction. When this occurs, clinic clients, particularly those who continue to engage in illicit drug use while in treatment, are more likely to withdraw from treatment than community clients, who are likely to attempt to address the problem with a service provider. Conversely, however, clients who experience goodwill, warmth and authenticity in their relationships with providers in addition to acceptance and respect are likely to find much unanticipated satisfaction with treatment. This is particularly true for those with a paranoid character, whose interpersonal anxiety is reduced by concrete gestures that provide evidence of another’s sincerity (Meissner, 1978). Clients who experience love from providers are likely to report feeling better about not only themselves but also the providers and to seek more program contact. This mutual transmission of the resource of love broadly accords with Rogers’s notion of the
reciprocity of positive regard, whereby individuals who satisfy another’s fundamental need for acceptance, respect and liking bring forth a reciprocal expression of these qualities from them (Rogers, 1951). The importance of providers, especially case workers and prescribers, showing goodwill to clients also accords with the findings of the client focus groups reported in Chapter 6. More broadly, evaluations of the effect of specific treatment processes on client outcomes have found that clients who perceive staff as caring, willing to help, patient and having similar ideas about treatment to them have reduced heroin use after one month in treatment and at six-month follow-up (Gossop, Stewart & Marsden, 2003).

Issues of status, information and service relationships were each found to be more narrowly defined than those of love. For both groups of clients, the absence of negative social stereotyping by providers was sufficient to ensure their satisfaction if not surprise. Where clients reported the use of these stereotypes, there were more immediate negative effects on the personal self of clinic clients, particularly for those with paranoid personalities, than community clients. However, the stigma acquired by community clients through the public exposure of their treatment status appears to have a significant effect on their social and occupational functioning, particularly in a small community. With regard to service provision and information, access to providers appeared to be the minimum normative expectation upon which community clients reported satisfaction. The slightly higher level of dissatisfaction from community clients in this area is not surprising given that, unlike clinic clients, many community clients in rural areas did not have access to a case worker at the time of interview. Community clients were pleasantly surprised by finding that providers were more competent and flexible than they had anticipated.

The results of this study indicate that the components of treatment noted as significant by clients relate to the resources of goods, services and money. With regard to goods, client satisfaction appears to be related to the degree to which the pharmacotherapy is effective. While most clients expect the opioid substitute will be effective, and many report positive changes in their life from its use, the minimum standard the drug must meet before clients will rate it as satisfactory is that its side
effects are tolerable. This is particularly true for clinic clients who expect to complete treatment within six months. That clients require the pharmacotherapy's side effects to be manageable is consistent with evidence that the negative somatic effects of methadone are one of the most consistent complaints of users of the treatment (Fisher et al., 2002; Goldsmith et al., 1984; Neale, 1998) and one of the reasons out-of-treatment heroin users avoid entering methadone programs (Weppner, 1979).

Issues related to the structure of service provision were found to be peculiar to the area of the program in which clients were based. For example, the convenience of dose collection was important to both types of clients, but differences in the rules regarding dosing for community and clinic clients were found to produce rather different client outcomes. Clinic clients, who are required to dose daily, were more likely to express dissatisfaction with the once daily time-limited dosing period while community clients, who can typically collect their dose any time within an eight-hour period, were likely to rate the flexibility this gave them as one of the satisfactory aspects of treatment. Differences in the structure of treatment within one area of the program also resulted in contrasting evaluations of treatment by the same clients. While clinic clients, particularly women, were more likely to find the security provisions immediately surrounding the dosing area unsatisfactory and anticipate intimidation from other clients because of this, once inside the locked dosing area and under the supervision of staff, they valued the privacy and security of the facility. The role of the treatment environment in structuring a culture that has particular challenges for women in opioid replacement treatment has been noted elsewhere (Fraser, 1997; Rosenbaum, 1981), and this result adds weight to that perspective. The remaining sources of dissatisfaction regarding the structure of service provision—namely, takeaway limits for community clients and time to admission to the program for clinic clients—were also specific to those in the affected client group.

Comparatively few issues regarding the cost of treatment were raised by the study participants. However, where dissatisfaction was reported, it had significant effects, with clients returning to the free clinic program when the treatment was no longer affordable. Given that all of the clients who transferred were on some form of
government income support, this result has important implications for attempts at encouraging more clients to move to the community sector. While not of the same scale, it is consistent with the results of the Victorian evaluation of community methadone dispensing, where three-quarters of the sample experienced problems paying for their treatment and 12 per cent of clients left treatment because of it (Lintzeris et al., 1996). Given most respondents in this study indicated that they expected to make a financial contribution to their care even while they valued the option of accessing free clinic service, it is possible that more clinic clients would be attracted to community dosing if the dispensing costs were standardised and comparable with those for similar medications.

In conclusion, the current study has found that, on the basis of the model proposed in this thesis, clients of the SAHS opioid replacement treatment program are largely satisfied with their treatment. This result is the product of clinic clients adjusting their expectations to accommodate their more frequent episodes of disappointment and community clients tending to be pleasantly surprised by many aspects of treatment. Where clinic and community clients are unsatisfied with treatment, their dissatisfaction has a more direct and immediate personal effect on clinic clients than community clients. This is particularly true for the interpersonal or process dimension of treatment, which concerns the way services are provided by frontline clinicians. Sensitivity in the delivery of treatment is especially important for clients with greater psychological needs or with a reduced commitment to treatment because of ongoing illicit drug use. While client dissatisfaction with the structure or content of the program is more likely to be registered by clinic clients, and notably by women and those with a short-term vision of rehabilitation, community clients on welfare are also vulnerable to dissatisfaction with this domain of treatment.

The power of these results in explaining client behaviour in treatment, however, is dependent on the theoretical model used to develop them. It is summarised and evaluated in Chapter 9. This chapter discusses the set of necessary elements comprising client expectations of opioid replacement treatment and considers how and to what
extent they can affect client attitudes and behaviour when certain treatment events occur.
Chapter 9 - Conclusion:  
The Value of Assessing Client Satisfaction with Opioid Replacement Treatment

Introduction

At the time of its introduction to Australia in the late 1960s and for the following 15 years, opioid replacement therapy developed mainly in clinic settings funded by the public sector. Since the mid-1980s, however, private modes of service delivery have flourished, mostly in response to the demand for treatment created by the adoption of a policy of harm minimisation, a reduction in the threshold requirements for entry into treatment and the introduction of alternative pharmacotherapies to methadone. Most recently, there has been an increasing emphasis on providing treatment in primary health care rather than clinic settings and on sharing service responsibilities between the private and public sectors. The effect on clients of the variation in service delivery that has inevitably resulted from this evolution of opioid substitution therapy has largely been neglected. As such, the degree of match that is being achieved between the needs of clients who present for assistance and the structure of the services from which they seek it, especially seen from the eyes of the clients, is relatively unknown.

This dissertation has sought to identify the clinical significance of evaluations made by clients in both clinic and community based opioid replacement treatment formats in order to identify the role satisfaction judgments play in client compliance with, and retention in, either of these modalities. A case study of a program incorporating both public sector clinic features as well as private sector community elements was conducted for this purpose. Client satisfaction was assessed with a modified version of a contemporary theoretical model founded on the assumption that satisfaction is the product of a process of expectancy disconfirmation. According to the model proposed in this thesis, client satisfaction was deemed to be a function of the degree to which clients’ experiences would fit within the boundaries of their normative expectations, not surpass or extend beyond them. In this way, satisfaction could be assumed to be based on the appropriateness of the treatment experience for clients, not
on the degree to which it either averted their mild disappointment or, conversely, matched their ideal or fantasised images of care.

The evaluation of client satisfaction using this model, and particularly in a program with two different treatment formats, of necessity required a dual evaluation—firstly at the level of the program to identify differences in the structure of treatment that shape client experiences in the clinic and community sectors; and secondly at the level of the clients in these sectors who would make evaluations based on their individual needs and circumstances. The three studies reported in this thesis aimed to describe these client and program factors impacting on client evaluations of treatment in addition to identifying the evaluations themselves and their reciprocal effect on both the client and the program. Grounding client evaluations within the context of the program structure meant that the information obtained would appear less arbitrary or haphazard while highlighting individual client narratives served to show that the experiences of clients based in either sector of the program are not governed by an unalterable script. Identifying the imputations clients make of unreflected or taken for granted treatment practices is not only of practical benefit to the clients and program under examination but also makes less opaque the kinds of treatment processes that influence client compliance with, and retention in, current opioid replacement therapies.

This final chapter has two aims. First, it seeks to situate the studies reported in the previous four chapters within the small but growing body of client-centred research evaluating the effect of treatment settings and practices on client responses to treatment. The implications of this evidence for the further evolution of opioid replacement treatment are considered. The second aim of the chapter is to consider the worth of the proposed model of client satisfaction in organising client responses to treatment and to identify areas where further development is required. To this end, this section documents the main characteristics of client expectations regarding opioid replacement treatment and the conditions under which they influence the attitudes and behaviour of clients participating in the everyday activities of the program. Before considering these issues, a brief recapitulation of the relevant studies and their main findings is warranted together with a short statement on how each might have been improved.
A Review of the Studies

The Assessment of the Treatment Setting

The study reported in Chapter 5 was a documentary analysis of the policies of the Southern Area Health Service (SAHS) and a series of semi-structured interviews with case managers, general practitioners and pharmacists in the program. Its purpose was to describe the treatment environment in which clients receive care, including the treatment philosophy of staff. As such, the program’s relationship to the community, its physical layout, the aggregated profile of its clients and staff, and the nature of its services, resourcing, administration and policies were documented together with the approach of clinical staff in developing and maintaining relationships with clients.

The results indicated that the SAHS is a geographically diverse yet very small rural and regional program providing a low level of treatment intervention. Clinic clients were found to be more supervised than community clients. Community clients were found to have generally fewer service options than clinic clients, such as less local access to free treatment and fewer choices of dosing pharmacies. The SAHS workforce was found to be stable and experienced, though community pharmacists have the least amount of peer contact and supervision. The providers interviewed all reported tensions in their working relationships with clients, particularly with new and unstable clients. These staff tended to emphasise the promotion of client responsibility and autonomy as a major task of the treatment process. They were found to take an adaptive, responsive position in setting the goals of treatment and to manage discrepancies between their ambitions for the clients and the clients’ wishes by reflecting on their increasing understanding of the treatment of addiction. The providers interviewed reported a combination of attitudinal and behavioural strategies for containing and stabilising difficult emotional encounters with clients.

On reflection, the validity of the self-report questionnaire data provided by clients regarding their treatment history in the SAHS could have been corroborated by reference to the clinical records of the program at the point when the documentary analysis was undertaken. This information was not obtained because the length of time
involved in gaining government approval to access confidential client information was considered prohibitive. The views of nursing staff in the clinic dispensary, who would encounter on a daily basis half the client sample, would have also provided a more fulsome account of the approach of service providers in the SAHS. The perspectives of former staff who no longer wished to participate in the program was also not obtained. It is possible that these service providers could have added more insight into the challenges of working with the client population.

The Pilot Study of Client Evaluations

The study reported in Chapter 6 was a pilot study using focus groups of clinic and community clients at one study site to identify their perspectives on the most important aspects of treatment in the SAHS. The results were evaluated in relation to the degree to which clients would regard as important issues relating to the process of treatment delivery as opposed to issues concerning its structure and content, thereby justifying the use of resource exchange theory to classify the dimensions of treatment.

The clients in this study were found to raise issues concerning their relationship to the treatment providers more frequently than issues concerned with the content of the program itself. In particular, both positive and negative issues involving love and services were raised in their consideration of the program’s general practitioners. However, issues related to general practitioners per se were the most infrequent of the issues identified in relation to the service providers. Similarly mixed responses involving the resources of love, status and services were provided in consideration of case workers, though community clients identified more positive experiences in discussing these staff. Mainly negative issues regarding dispensers, particularly community pharmacists, were raised, and these involved the resources of status and money. The major limitation of this study was that the views of members in each focus group tended towards homogeneity, which, in the absence of greater moderator involvement, potentially narrowed the opportunity for dissenting or alternative viewpoints to be expressed. This problem was somewhat allayed by the tendency for different groups to express contrasting views on the same topics.
The Main Study of Client Satisfaction with Treatment

The third study, reported in chapters 7 and 8, was an investigation of significant treatment experiences for a sample of community and clinic clients in the SAHS. The profiles of both client groups on which these experiences were assumed to be based is reported in Chapter 7. Using a series of quantitative self-report questionnaires, the analysis of client profiles aimed to identify whether there were significant differences in the treatment history, drug use patterns, demographic features and social, physical and psychological functioning of clinic and community clients. Community clients were found to be significantly older than clinic clients. However, this difference was not found to impact on other differences between the groups, including the more frequent treatment attempts, greater level of psychopathology and concurrent illicit drug use and lower level of social functioning of clinic clients. Community clients were also found to have been in treatment at the SAHS longer than clinic clients and to rate their problems as less severe than clinic clients.

Chapter 8 outlined the results of the client reports obtained through individual unstructured interviews. In particular, it detailed the areas of treatment clients regarded as satisfactory and those deemed unsatisfactory, the sources of those evaluations and their impact on both the clients and the program. It also documented the processes clients engage in when making decisions about their involvement in treatment. The results indicated that the majority of clients were satisfied with treatment, generally because of accommodating their expectations of treatment to their experiences. Community clients who expressed dissatisfaction tended to seek redress of their problems by approaching the service providers concerned while clinic clients tended to withdraw and seek personal solutions, particularly when it concerned the manner of treatment delivery by staff.

Given that most participants to this study were self-selected, it is possible that the results represent the views of a biased sample of the SAHS treatment population. In other words, those who agreed to participate did so because they had a particular point of view to convey that was not typical of most clients in the program. This said, efforts
to obtain the views of clients across all treatment districts of the program, to ensure a balance in the number of clinic and community clients sampled and to interview both new and experienced clients in the program increased the probability of gathering a diverse range of perspectives. The client sample was also comparable in age and gender with the population of clients in other New South Wales opioid replacement programs. The research is only a single cross-sectional snapshot capturing the retrospective accounts of current clients, not those who may have dropped out of treatment, so it is not possible to identify the longer term consequences of unsatisfactory client experiences. Further, given that the views of only one-third of the total client population were obtained, some caution must be exercised in considering them representative of the views of all clients in the program. To some extent, the inability of studies conducted at a single point in time to make stronger conclusions about client behaviour in the longer term is a problem applicable to all client satisfaction research. It is also one that may be ameliorated to some extent by incorporating regular reviews of client satisfaction into other ongoing organisational quality assurance activities.

Client Satisfaction as an Indicator of Treatment Effectiveness

The Pharmacotherapy

The studies reported in this thesis clearly show that clients consider the effectiveness of the pharmacotherapy itself as one of the key benefits of opioid replacement treatment. Eighty per cent of the sample in the main client study were using methadone while the remainder were using buprenorphine. The median dose for those on methadone was 50 milligrams while for buprenorphine it was 10 milligrams. Both of these doses are at the lower end of the moderate dose range considered useful for maintenance treatment (Lintzeris et al., 2004; Ward, Mattick & Hall, 1998). The majority of clients indicated that they considered their current dose satisfactory, which suggests that most deliberately wish to keep their dose at a lower level. Client concerns about side effects and the difficulties of withdrawing from the opioid substitute may well explain this outcome. At least for clinic clients, maintaining a lower dose is partially related to the desire to continue to use heroin, whereby methadone is seen as a 'backstop' when heroin is difficult to procure.
Buprenorphine appeared to be taken up by clients either in response to the negative side effects of methadone and/or as part of a goal to complete treatment within six months. While many clients reported an interest in a treatment that provided them with the opportunity to dose less frequently and to reduce symptoms of lethargy, several indicated that they did not yet know enough about the side effects of the drug in order to be able to make an informed decision about its appropriateness for them. Literature about buprenorphine and its side effects developed by a national drug user representative organisation specifically for clients was available from the SAHS at the time of the main study. However, given the treatment was in its infancy, it is possible that this information was still at the stage of being disseminated, particularly in regional areas of the program. Evidence from other areas in Australia suggests that client interest in, and trialling of, buprenorphine maintenance is likely to continue to increase markedly. For example, one year after its introduction, Victoria reported that 39 per cent of all patients enrolled in opioid substitution programs were being treated with buprenorphine (Lintzeris et al., 2004). At the time of writing, there is no reason to suggest that buprenorphine dosing will not increase in a similar fashion in the SAHS.

Dosing Arrangements

The successful implementation of maintenance opioid replacement treatment in not only clinics but also, and perhaps especially, in community based program depends on the management of the stigma that inevitably attaches to both providers and clients attempting to deal with the effects of illicit drug use. One of the arguments often cited in the promotion of community based treatment is that individual clients are less likely to be identified as drug users in primary care settings than in specialist drug treatment clinics. This is associated partly with the smaller numbers of clients attending each provider and partly with the policy redefinition of drug dependency as a health problem with broader personal and social effects rather than a disease affecting a marginalised group in society. Many of the community clients interviewed in this research, however, reported stigma, or exposure of their status as former drug users, arising through the treatment practices encountered at their local pharmacy. In comparison with the service received by other customers of the pharmacy, many of these clients believed their being
served out of turn or after noticeable delays was based on discriminatory or stereotypical attitudes towards illicit drug users held by their pharmacist. Given the limited number of treatment options for community clients in small towns, almost half reported simply accommodating to their lack of power to change these practices and developing situational coping strategies to avoid being recognised by other customers.

These results are consistent with findings from the Victorian evaluation of community methadone services, where 40 per cent of clients reported tensions in their relationship with pharmacists over perceived preferential treatment provided to non-methadone customers based on the order of service (Lintzeris et al., 1996). Perhaps in response to this work, the Victorian branch of the Pharmaceutical Society of Australia developed a consumer rights charter for clients receiving methadone, buprenorphine and other pharmacotherapies. The charter lists several rights that clients can expect to receive in treatment, at the top of which is ‘prompt, quality pharmacy service’ and ‘professional treatment that is fair and equitable, without prejudice’ (Commonwealth Department of Health and Ageing, 2002:193). The charter also lists avenues of redress for breaches of its terms.

At present it is unclear whether clients in other states, including New South Wales, are covered by a similar charter or, if they are, whether this information is disseminated to them at the commencement of their treatment. Certainly the clients interviewed in these studies did not report a tendency to seek assistance with problems from advocate organisations or authorities. The reasons for this remain unclear. Most current community providers in the SAHS would not have been privy to formal training regarding these issues. However, the stigmatising effects of failing to serve clients promptly and in order are addressed in a recently developed national training program for pharmacists as part of the National Illicit Drug Training for Pharmacy Project (Commonwealth Department of Health and Ageing, 2002).

Another concern expressed by the majority of community clients regarding dosing arrangements is the lack of privacy at pharmacies. In considering this point, clients regularly reported being dosed in full view of other customers and notified of
their payment arrangements publicly. Once again, for clients in small towns who often must depend on a sole pharmacist to receive treatment, this was particularly problematic. Beyond complaining or developing tactics to hide their recognition by other customers, most clients spoke of the problem with a sense of powerlessness. The highly regulated nature of methadone or buprenorphine dosing, which means that the ingestion of doses must be supervised, differentiates clients receiving this treatment from other pharmacy customers, thus potentially highlighting their identity. In line with the standard duty of care of health care professionals to protect patient confidentiality, it would therefore seem that discretion in administering opioid replacement treatment is particularly important. Indeed, current treatment protocols for pharmacists endorsed by the Pharmaceutical Society of Australia and the Pharmacy Guild of Australia stress the importance of upholding patient confidentiality, especially in regional areas and smaller communities. As such, they recommend that dispensing be performed in a separate room or quiet area of the pharmacy and that patient records not be visible to other customers or clients (Commonwealth Department of Health and Ageing, 2002). It is not clear to what extent pharmacists in the SAHS are aware of the association between their current dosing practices and their duty to protect client confidentiality.

For clinic clients, the greatest concern regarding dosing arrangements appears to be the restrictive nature of the clinic opening hours. For at least half of these clients, the problem with the limited dosing time was associated with the delays encountered because of buprenorphine dosing. In 2005, the three-hour dosing period was reduced by 10 minutes to account for the extra staff time involved in buprenorphine dispensing. While this appears to be a suitable response to staff needs, it comes at the cost of even more restricted service availability for these clients. An alternative response to this issue more suited to the needs of both providers and clients has been developed in Victoria, where pharmacists use a commercial tablet crusher to administer Subutex as a powder. In this form, buprenorphine appears to dissolve more quickly, reducing the time required for supervised dispensing. The bioequivalence of crushed tablets, however, has not been established (Lintzeris et al., 2004).
At the time of the main client evaluation, client safety in the immediate vicinity of the clinic dosing area was also identified as a concern by one-quarter of clinic clients, all women. The provision of a safe treatment environment is important in conveying to clients not only that they will be free from harassment and intimidation in treatment but also that the treatment will be reliably and consistently monitored and limits will be enforced. The introduction of video surveillance around the clinic premises in 2005 may partially address this issue.

Ancillary Services

Limited access to counselling through a case worker was a raised by very few clients in this research. In both the focus groups and individual interviews, these clients indicated that while they felt comfortable approaching their case worker for assistance, the restricted availability of these providers was a disappointment to them. On balance, however, clients appeared to be satisfied with the responsiveness and availability of case workers for counselling when it was sought.

While many clients discussed the importance of their prescriber taking an interest in their general health, most clients appeared to approach their engagement with the program’s general practitioners on the basis of drug issues and to consult other medical practitioners for their general health needs. As such, there was little expression of need for additional medical services by the clients interviewed in this research. Nonetheless, the interest in clients’ general health shown by the prescribers appears to serve an important function in enhancing the treatment relationship between these providers and clients. For many clients, particularly those based in the clinic, prescriber interest in their wellbeing came as a pleasant surprise.

The Cost of Treatment

The studies in this thesis indicate that there is notable variation within different regions of the program and across programs in the dispensing fees payable by clients. Further, there appears to be no upper limit on what can be charged. The average weekly treatment fee being paid by community clients was approximately $35 per week. For
clients receiving the unemployment benefit, which amounts to approximately $180 per week, treatment fees account for approximately 20 per cent of their weekly income. Accordingly, the minority of clients who reported experiencing trouble meeting the cost of treatment were receiving some form of government income support payment. On the whole, it appears that the clients interviewed in the program do not expect to be granted credit for outstanding accounts. This may be partly related to the use of sanctions by pharmacists, such as those interviewed in Chapter 5, who both indicated that they placed temporary restrictions upon providing takeaway doses to clients in arrears.

While ascertaining the cost incurred to pharmacists or the SAHS for providing opioid replacement therapy sits outside the ambit of the current project, from the perspective of the clients it appears that placing a limit on the costs borne by them is necessary if financial considerations are not to become a significant impediment to their retention in treatment over time. Retaining the option of free service through either the clinic or local district hospitals would appear to be a minimum safety net in this regard. Other commentators have recommended that the pharmacotherapy be subsidised by the Commonwealth through its inclusion on the pharmaceutical benefits scheme in order to alleviate the financial stress on both providers and clients (Lintzeris et al., 1996). This may be particularly appropriate given that methadone continues to be the most cost-effective treatment for opioid dependence in Australia and community treatments have been found to cost less per client than clinic based ones (Mattick et al., 2004).

The Quality of Staff-Client Relationships

Despite frictions in the treatment relationship arising from the management of client status, the quality of the relationships between service providers and clients in the SAHS was found to be generally positive. In both the focus groups and individual interviews, clients described their relationship with prescribers in the most positive light, often because the prescribers reportedly evinced personal qualities not previously experienced by similar practitioners in other programs. These included an interest in the client's general wellbeing, as noted earlier, as well as warmth and genuineness in their manner of engagement. Prescribers were also the most likely to respect each client's
right to confidentiality and to support his or her choices in treatment. On balance, clients expressed confidence in their prescriber's knowledge and competence. Where reservations were expressed, these related to the prescriber's knowledge of the side effects of buprenorphine and specific issues related to relapse. Once fortnightly access to their prescriber was the most significant negative aspect of the treatment relationship identified by clients. The average of eight years experience of all three SAHS prescribers and their engagement in mandatory training for their role may have contributed to the overall positive treatment relationships identified in this research.

Client relations with case workers in the SAHS appear to involve more ambivalence. This was found in the focus groups as well as the individual interviews. Like prescribers, there was appreciation of case workers who demonstrate goodwill, friendliness and authenticity in their approach to clients. However, many community clients, particularly those in small communities, expressed dissatisfaction with the level of respect for their privacy shown by some case workers. Similarly, a small number of clinic clients expressed doubts about the degree to which they felt accepted by their case worker. Most clients appeared to value the skills and knowledge of their case worker and the ease and flexibility with which these providers were able to perform their duties. However, two sources of tension in the relationship with case workers was the perceived inconsistency in the speed in which they could complete tasks and their level of availability for counselling. The increased staff-to-client ratios in 2003, where there were vacancies for four full-time case workers in the SAHS, may go some way towards explaining these service provision difficulties.

The relationship between clients and dispensers, mostly community pharmacists but also clinic dispensing nurses, appears to contain the potential for the most problems. As discussed earlier, a significant concern for community clients is the inadvertent exposure of their status as former illicit drug users through the practice of supervised dispensing in public areas of the pharmacy. Another source of conflict in client-pharmacist relationships is the management of dispensing fees. For clinic clients, tensions are most likely to arise from perceptions of discrimination where doses are withheld because of intoxication and when random urine tests are conducted. In part,
these difficulties may appear more prevalent simply because dispensers are the providers with whom clients have the most frequent contact on the program. Often working alone, community pharmacists are also the most isolated providers in the service and, as the interviews in Chapter 5 show, are least likely to seek regular consultations with other program staff.

The Influence of Client Characteristics

The demographic profile of the clients sampled in both the focus groups and the main evaluation is similar to that of clients in similar Australian opioid substitution programs. While being slightly older than other samples, most clients were in their mid-30s, male, had a junior secondary level of education and were dependent on government income support payments. In line with other samples, the client group as a whole was found to have a high level of psychopathology. As would be expected for a group who had spent longer in the SAHS program, community based clients were older than their clinic based peers. However, this difference was found to exert little influence on other functional differences found between these groups.

Current SAHS policy is to retain clients with more complex needs in the clinic and hospital environments and transfer to the community stable individuals who adhere to service contact obligations and other program rules, show no signs of intoxication and demonstrate appropriate social behaviour. The effects of this practice were borne out by the results reported in Chapter 7. In a comparison of clinic and community clients, individuals based in the clinic considered their problems more severe, had had more attempts at opioid replacement treatment and were more likely to continue to engage in illicit drug use. Clinic clients were also found to have a higher level of characterological problems and lower level of social functioning than community clients.

To the extent that clients with these characteristics are choosing to remain in the clinic environment or are actively discouraged from transferring to the community sector is difficult to determine. Many clinic clients cited the cost of dispensing fees and perceived discrimination towards program clients from local pharmacists as a
disincentive to transfer. Given the limits that must inevitably be placed upon the number of free public treatment places, a policy decision will need to be made on the extent to which current long-term treatment recipients will be allowed to hold clinic places to the exclusion of younger heroin users who would like to commence treatment. This constraint invites debate about the optimum duration of meaningful treatment. In the SAHS, the median treatment duration for clinic clients was found to be almost two years while for community clients it was four.

In both the standardised questionnaire as well as the individual interviews, both clinic and community clients were found to rate the global quality of the treatment environment as satisfactory. However, the results reported in Chapter 8 show that clinic and community clients appear to react to unanticipated events or aspects of their treatment in quite different ways. As the results of that study show, both favourable and unfavourable treatment experiences tended to have a greater immediate effect on the self of clinic clients than community clients. In part, this was due to a number of client factors that define differences in the needs of clients in the two sectors. For instance, dissatisfaction with the way providers deliver treatment was more likely to result in responses from clinic clients that came at greater personal cost, such as withdrawal, a return to illicit drug use or moving elsewhere on the program. Conversely, community clients were more likely to respond by engaging others, such as the provider, to help resolve the issue or finding a way to adapt to the unsatisfactory situation. Having characterological difficulties or continuing to use illicit drugs was associated with an increased likelihood of clients choosing a less adaptive response to treatment problems. Alternatively, positive experiences had a more potent personal effect on clients with particular personality traits. In summary, the influence of personal characteristics on client responses to treatment underlines the importance of centres that cater to clients with special needs having appropriately trained staff able to deliver sensitive interventions.
The Influence of Program Structure and Provider Philosophy

As noted in Chapter 2, the format and delivery methods of treatment services has been found to be a significant factor in the effectiveness of opioid replacement treatment (Ball & Ross, 1991; Bell et al., 1995). One of the aims of the current research was to examine the influence of organisational constraints and program provider philosophy on shaping client satisfaction judgments, thereby contributing to the evidence available regarding this issue. Evaluating a treatment program containing both public sector clinic elements and private sector community features afforded an opportunity to identify the influence of a variety of treatment components on client evaluations while examining the philosophy of its main providers created a context for understanding client assessments regarding the manner of treatment delivery.

The results of this research project show that variation in the structure of specific treatment components impacts on client satisfaction notwithstanding the needs or profiles of clients based in different sectors of the program. For example, convenient dosing times was a central concern of many clients in the main client study. However, different rules regarding the collection of doses for clinic and community clients resulted in rather different outcomes for these client groups. As found in Chapter 8, clinic clients registered dissatisfaction with the clinic's limited once-daily dosing schedule, particularly given the requirement to dose every day, while community clients considered one of the advantages of treatment was the capacity to obtain takeaway doses and to collect their doses at any time during the pharmacy's opening hours. Similarly, both types of clients valued the ability to have affordable treatment, particularly given their generally low incomes. However, the cost of dispensing fees was a particular source of dissatisfaction for community clients while, alternatively, the free clinic service was seen as a positive feature of treatment for clinic clients.

Considered together, the results of the main client study and the interviews with program staff indicate that the approach of treatment providers to delivering care in general appears to be individualised, client-centred and, therefore, therapeutic. The ability of clients to exercise a degree of control over their treatment, the integrity and
reliability of staff and the frequency and duration of the treatment relationship have been identified as ingredients of successful treatment relationships in opioid substitution treatment (Lilly et al., 1999; 2000). The results of interviews with a selection of service providers in the SAHS appear to concur with these findings. These providers considered one of the main psychological tasks of treatment to be helping clients take responsibility for themselves. One way they reportedly achieve this is to provide clients with an experience of making their own choices in treatment. The SAHS providers, guided by harm minimisation principles, also reported taking a responsive position in negotiating treatment goals with clients. Finally, in managing the emotional elements of the treatment relationship, these providers highlighted the significance of following through on verbal commitments, demonstrating consistency in their treatment practices and acknowledging the amount of experience required to understand what works in treatment relationships.

The effectiveness of the approach to treatment reported by these SAHS providers is suggested by the client evaluations of experiences involving providers considered in Chapter 8. As was discussed in that chapter, issues involving the particularistic resources of love, status and services were identified in relation to treatment providers together with the resource of information. Of the items related to the resource of love, the vast majority were rated positively by clients. In particular, most clients were pleasantly surprised by the genuineness of providers and their acceptance of them and their treatment choices. With regard to service consultations with providers, again, most clients rated SAHS program staff positively. For a significant number of clients, the responsiveness to requests and flexibility in arranging services reportedly shown by these providers was unexpected, mainly because they had not experienced it in other programs. Finally, while the providers reported being responsive to client treatment goals, the clients indicated that they were happy to be guided by the knowledge and competence of treatment staff.

The area of client-staff relationships most consistently rated as poor by clients concerned issues of status. As was considered earlier in this chapter, these issues related to perceived discrimination by providers through their requests for random urine tests,
withholding of doses because of intoxication, serving clients in full view of the public or dealing with clients slowly or out of turn. While the service of clients in pharmacies may be shaped by the practical exigencies of those environments, urine testing and refusals to serve intoxicated clients are associated with the enforcement of the public health regulations surrounding opioid replacement treatment in clinic environments. As such, these latter activities which clients rate negatively may reflect the point at which providers must choose to uphold public health regulations at the expense of individual client wishes. To the degree that the interests of the general public are accorded greater weight than those of clients, clients therefore perceive this as discrimination.

The Effectiveness of the Model of Client Satisfaction

The Importance of Expectations in Client Evaluations

The model of client satisfaction developed in this thesis is based on the expectancy disconfirmation paradigm (Zegers, 1968). This means that satisfaction is assumed to be a post-experiential attitude that is assessed according to the amount of discrepancy between a standard, such as expectations or values, and perceived events. According to the approach used in this theory, the discrepancy between expectations and events is either assimilated when it is minor or exaggerated when it is too large. As such, expectations exert a curvilinear influence on the evaluation of events. This theoretical approach explains why there is so little variation in the commonly high levels of reported satisfaction.

The most comprehensive version of an assimilation-contrast model of client satisfaction available at the present time is one designed for use in consumer marketing research (Thompson & Sunol, 1995). Accordingly, some of the basic assumptions on which it is built were considered inappropriate for assessing satisfaction among health care clients, particularly those receiving chronic levels of care, such as clients of opioid replacement therapy. A reformulated version of the model was developed for this project. First, it assumes that client satisfaction is a function of the appropriateness or accuracy of the treatment in relation to the client’s normative expectations, the boundaries of which are determined by the client’s needs as well as by the structures
and rules governing the operation of the program in which they receive care. Second, it assumes that the clients with greater personal and social needs will have a narrower zone of tolerance for unmet normative expectations regarding the process of treatment delivery than for the outcomes or components of the treatment.

The results of the main client evaluation lend partial support to the value of these assumptions. The reasons for this can be understood by reference to Figure 9.1, which shows the reformulated model of client satisfaction used in this research. The area covered by grey shading is the zone of tolerance within which satisfaction is registered. The areas both above the achievable norm and below the minimum normative prediction is where dissatisfaction is registered.

![Figure 9.1](image)

**Figure 9.1** The model of client satisfaction tested in this research.

In general, the experiences registered as unsatisfactory for the clients in this research were rated as such because they did not reach the minimum normative standard of service. As such, dissatisfaction was mostly found to be based on a deficit of services or care. In only a few areas did clients consider that either staff performance or the components of the treatment provided were excessive, intrusive or overblown, which is
represented in the diagram by events falling above the achievable normative expectation. Put another way, there is a level of service or provider response that is considered sufficient or adequate by clients and anything beyond it will be regarded as unsatisfactory because it represents an unnecessary incursion into the lives of clients. In only a few areas of treatment was the service considered intrusive enough to produce a behavioural response from clients. These included events involving status, where dissatisfaction was registered because clients considered the use of stereotypes and their exposure too excessive to be tolerable. Similarly, clients were likely to respond negatively when the side effects of their methadone dose and the cost of treatment were too great to remain manageable. With the exception of pharmacotherapy dose levels, where an insufficient amount would produce dissatisfaction because clients would be likely to continue to experience cravings, issues of status and money appear to have no viable expectable minimum. For example, a complete absence in the use of stereotypes would be regarded as satisfactory by clients, as would free treatment. In other words, even while clients expect that stereotypes are likely to be used to some degree and treatment will probably result in some financial impost, they are not likely to register dissatisfaction when these probabilistic expectations are disconfirmed and neither eventuates. This anomaly does not entirely discredit the model as it is currently structured. Nonetheless, it suggests that there are aspects of health treatment where satisfaction exists in a skewed curvilinear relationship to the perceived sufficiency of the services provided.

There appears to be qualified support for the assumption that clients with greater personal and social needs have a narrower zone of tolerance for unmet expectations regarding the processes of treatment delivery. As was considered earlier in this chapter, clinic clients were found to have greater levels of illicit drug use and psychopathology, poorer social functioning and to have made more attempts at treatment than community clients, reflecting their greater needs in these areas. Accordingly, clinic clients also registered a higher total level of dissatisfaction than their community peers. However, while clinic clients recorded fewer instances of dissatisfaction with issues related to the particularistic resources of love, status and service consultation than community clients,
the effect of unmet expectations regarding these issues had more disruptive personal effects on them than community clients. In short, the assessment that clinic clients have a greater intolerance for unmet expectations regarding treatment delivery at this stage can only be derived from the more deleterious effect of breached normative expectations on these individuals, not their greater frequency.

With regard to the essential features of client expectations in opioid replacement treatment, the results of the main client study suggest that the minimum normative expectations by which clients consider the performance of service providers to be satisfactory are that providers respect individual client differences, do not reinforce community stereotypes of drug users and are available and open to clients. Most clients predict that these expectations will not be met. This is most likely to be true for clients with a certain personality style, those with a reduced commitment to treatment because of ongoing illicit drug use and community clients. The minimum normative expectations by which clients consider the components of treatment to be satisfactory are that the pharmacotherapy is safe and effective, the environment in which they collect it is safe, accessible and reliable and the treatment is affordable. Most clients predict that these expectations will be met. When they are not, it is most likely the case for women, those on income support payments or those intending to complete treatment imminently.

The Utility of Resource Exchange Theory in Assessing the Domains of Treatment

The model utilised the principles of resource exchange theory to classify the two basic domains of treatment—namely, the processes of treatment delivery and the components of the treatment itself. According to the theory, the resources of love, status and services are particularistic in nature because their successful transmission depends on the quality of the relationship between those who exchange them. As such, these resources are capable of representing the way program staff deliver treatment. The resources that are not dependent on the nature of the relationship between the parties for their successful exchange are information, goods and money. These were considered capable of representing the various components of opioid replacement therapy associated with the
program or institution of treatment per se. The main benefit of employing resource exchange theory in the model is that it was considered to provide a coherent classification system without pre-empting the specific categories of treatment clients would nominate as significant.

The results of the main client study indicate that, like most descriptive theories based on categorical relationships, the relationship between items at the boundaries of different resource classes is somewhat blurred. For example, the resource category of services was found to contain both particularistic and non-particularistic items, and the resource of information was found to contain more particularistic items than was originally envisaged by the theory. Given the large number of items in the services category, partitioning this variable according to the particularity of the items contained in it was a useful analytical heuristic. Importantly, therefore, any overlap of items across neighbouring resource categories was not found to detract from the conceptual coherence afforded by the use of resource exchange principles in organising the data. Given the universal qualities of its categories, resource exchange theory could be fruitfully employed in the evaluation of many different service organisations.

Conclusions and Recommendations

The studies reported in this thesis contribute to the growing literature examining the effect on client retention of the format and delivery of opioid replacement therapy. In particular, they provide new information about the effectiveness of this treatment when it is provided in rural and regional areas. This examination of the SAHS has also provided some evidence of the effectiveness of matching clients with particular styles of treatment.

The results of these studies indicate that the interpersonal manner of treatment delivery is as significant to maintaining client satisfaction in treatment as the content of the treatment itself. In addition to the pharmacotherapy, what has the potential to be therapeutic for clients, particularly in a maintenance environment, is stable or reliable experiences of providers being competent, acting flexibly, demonstrating a genuine interest in the client’s perspective and not enacting stereotypical attitudes regarding
drug users. Positive experiences in this regard were found to not only increase client self-esteem but also increase client contact with the service and improve client attitudes to providers. Conversely, a lack of acceptance of clients and respect for their privacy and right to self-determination had negative effects for both the clients as well as the service. Importantly, these results show that therapeutic treatment alliances can be created from the framework of the basic everyday interactions between staff and clients, not just in formal counselling services. Further, the maintenance of effective treatment relationships is particularly important for clients with special needs and complex presentations, such as those found in the public sector.

Examining the interpersonal dimension of treatment also highlights the importance of identifying the meanings underlying client behaviour. Treatment practices or structures designed to serve one function may have unintended effects because staff and clients believe they are being performed for quite different reasons. For example, while pharmacists may dose clients in open areas of the pharmacy for practical reasons, clients appear to interpret this as evidence of their discriminatory attitudes to drug users. Conversely, while prescribers may simply consider it part of their role to resolve problems with scripts, clients tend to interpret their efforts as evidence of their goodwill.

With regard to the components of treatment, these studies indicate that clients are likely to be increasingly attracted to alternative pharmacotherapies such as buprenorphine once they consider they have sufficient knowledge of their effectiveness and side effects. With changes in dosing practices that reduce the time taken to dispense it and with the potential for takeaway doses to be administered, buprenorphine may not only alleviate the pressures created for both client and provider at the point of administration but reduce the dispensing fees for community clients through less frequent contact with the pharmacy.

Apart from the benefits to be obtained by an increasing number of pharmacotherapy treatments, it appears that clients, particularly those in regional areas with fewer treatment options, are vulnerable in disputes with local service providers and
have limited recourse over unsatisfying treatment practices beyond complaining to the provider in question. Given that clients have less power in a one-to-one treatment relationship with providers, especially in a decentralised treatment environment, it is important that there be well-established avenues by which client concerns receive a fair and impartial review, such as through a third party advocate. At a minimum, all providers need to alert clients to their rights as well as their responsibilities in treatment and to have procedures in place for monitoring them.

Assessing client expectations of treatment as a way of explaining client behaviour and, therefore, drawing conclusions about the level of client satisfaction in treatment appears to be conceptually satisfactory. While client expectations are not always conscious, logical or acted upon, they nonetheless have practical relevance in identifying the minimum standards of treatment acceptable to clients. Further research is required, however, to confirm whether satisfaction is entirely a function of the appropriateness of the treatment response for the individual client. The results of this research indicate that there are some treatment experiences, such as free treatment and services that do not reinforce community stereotypes, which, through their mere presence or absence, will be sufficient to produce satisfaction among clients generally. Finally, where positive behavioural outcomes result from satisfying experiences, it is unclear whether these are the product of pleasant surprises, clients re-evaluating their mild disappointments or an exact match being achieved between what clients received and what they expected to receive. Such questions go to the heart of the process of client change. Organisations that understand this process and tailor their services according to it are likely to provide more effective treatment.
References


**Software**


Appendices

Appendix A – List of Inductive Coding Themes and Descriptors for Service Provider Interviews

QSR N6 Full version, revision 6.0.
Licensee: School of Psychology.
PROJECT: Service providers in ORT, User Myra, 1:00 pm, Apr 7, 2005.
REPORT ON NODES FROM Tree Nodes
Depth: ALL
Restriction on coding data: NONE

(1) /background info

(1 1) /background info/age

*** Definition: age of provider

(1 2) /background info/time in current

*** Definition: provider’s time in current position

(1 3) /background info/reason for getting job

*** Definition: reason for seeking current position

(1 4) /background info/training

*** Definition: formal training for current position and adequacy

(1 5) /background info/time in field generally

*** Definition: amount of experience in specialty/discipline

(1 6) /background info/title

*** Definition: title of current position

(2) /caseload

(2 1) /caseload/assessment process

*** Definition: approach to assessing prospective clients

(2 2) /caseload/contact with other providers

*** Definition: amount and nature of contact with peers in the program and outside it re clients
(2 3) /caseload/number of clients

*** Definition: size of current caseload

(2 4) /caseload/caseload description

*** Definition: features of caseload - age & gender break-up of current clients, clients' length of time with provider, changes in size or nature of overall client load over time in position and reasons for this

(3) /relationship themes

(3 1) /relationship themes/contingency management

*** Definition: examples of client lapses of responsibilities that are followed up and action taken; beliefs about need for, and effectiveness of, contingency management for client and for provider

(3 2) /relationship themes/client contact

*** Definition: statements about frequency of contact with clients and need for it

(3 3) /relationship themes/holistic concern

*** Definition: statements about the need to consider aspects of the client’s care beyond providing just pharmacotherapy dose; statements about caring for clients’ families and broader health and social concerns.

(3 4) /relationship themes/treatment goals

*** Definition: provider understandings about client goals for treatment and provider beliefs of what are appropriate treatment goals

(3 5) /relationship themes/joint problem solving

*** Definition: issues of collaboration with clients and division of power in the relationship; provider approaches to collaboration

(3 6) /relationship themes/responsibility of self

*** Definition: aspects of the treatment relationship where provider is responsible and reasons for this
(3 7) /relationship themes/responsibility of clients

*** Definition: aspects of the treatment relationship where client is responsible and reasons for this

(3 8) /relationship themes/nature of addiction

*** Definition: provider ideas about the sources of addiction and how clients overcome them

(3 9) /relationship themes/different client types

*** Definition: ideas about treating clients as individuals, not according to stereotypes of drug users; comments indicating differences in clients based on stages of recovery and motivation; comparisons of clients with members of general community

(3 10) /relationship themes/containment of self

*** Definition: comments about managing emotional reactions or stress in working with clients

(3 11) /relationship themes/importance of team

*** Definition: comments about the importance of colleagues and learning acquired through working closely with other experienced individuals

(3 12) /relationship themes/liking the clients

*** Definition: statements indicating a genuine liking of, interest in and respect for clients

(3 13) /relationship themes/things learnt from clients

*** Definition: information about clients' perspective or subjective experience of aspects of treatment acquired in the process of engaging with them

(3 14) /relationship themes/containment of client

*** Definition: ideas about how to manage client distress and minimise its recurrence; situations where emotional management is necessary

(3 15) /relationship themes/denial/honesty

*** Definition: comments about the honesty of clients when approached about their problems
(3 16) /relationship themes/empowering the client

*** Definition: ideas about, and evaluations of the importance of, promoting client self-reliance in treatment and beyond

(3 17) /relationship themes/consistency in approach

*** Definition: comments on the importance of providers being consistent in their approach to clients

(3 18) /relationship themes/relationship building

*** Definition: ideas about how relationships with clients are developed and the effect on outcomes of having a sound treatment relationship
## Appendix B – Conceptually Ordered Matrix of Service Provider Approaches to Relationships with Clients

<table>
<thead>
<tr>
<th>TASK COLLABORATION</th>
<th>TREATMENT GOALS</th>
<th>AFFECTIVE BOND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency management</td>
<td>Treatment goals</td>
<td>Client contact</td>
</tr>
<tr>
<td>Joint problem solving</td>
<td>Nature of addiction</td>
<td>Holistic concern</td>
</tr>
<tr>
<td>Responsibility of self</td>
<td>Different client types</td>
<td>Containment of self</td>
</tr>
<tr>
<td>Responsibility of clients</td>
<td>Denial/honesty</td>
<td>Importance of team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liking the clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Things learnt from clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Containment of client</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Empowering the client</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consistency in approach</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationship building</td>
</tr>
</tbody>
</table>
Appendix C – List of Inductive Coding Themes and Descriptors for Client Focus Groups

Q.S.R. NUD.IST Power version, revision 4.0.
Licensee: Myra.
PROJECT: Client satisfaction with ORT, User Myra, 11:41 am, Jan 18, 2003.

(1) /clients

(1 1) /clients/time in ORT

*** Definition: length of time in ORT generally

(1 2) /clients/ORT reasons

*** Definition: reasons for commencing ORT

(1 3) /clients/time in SAHS

*** Definition: length of time in SAHS program

(1 4) /clients/SAHS reasons

*** Definition: reasons for joining SAHS program

(2) /case worker

(2 1) /case worker/learning

*** Definition: learning from case worker about rights and responsibilities on program and available services

(2 2) /case worker/follow-ups

*** Definition: telephone follow-ups for missed clinics as an expression of care

(2 3) /case worker/helpfulness

*** Definition: comments regarding case worker’s attitude to providing assistance with problems

(2 4) /case worker/persistence

*** Definition: persistence by case worker in ascertaining wellbeing of clients

(2 5) /case worker/trust

*** Definition: expressions of earned trust of case worker via recognised good behaviour
(2 6) /case worker/case consultation

*** Definition: comments regarding process of case consultation and follow-ups

(2 7) /case worker/counselling

*** Definition: comments regarding counselling with case worker, including quality and amount

(2 8) /case worker/dosing time

*** Definition: comments regarding dosing time at the clinic where case worker is involved in dosing

(2 9) /case worker/services

*** Definition: issues regarding the availability and range of services provided by case worker

(2 10) /case worker/status concerns

*** Definition: statements expressing a sense of moral evaluation of clients by case worker

(3) /doctor

(3 1) /doctor/dose

*** Definition: comments about setting a suitable dose level with doctor

(3 2) /doctor/takeaway number

*** Definition: issues related to the number of takeaways issued by doctor

(3 3) /doctor/takeaway policy

*** Definition: doctor’s attitude to takeaway doses from clinic

(3 4) /doctor/learning

*** Definition: learning from doctor about rights and responsibilities on program and available services

(3 5) /doctor/interest

*** Definition: interest by doctor in clients’ general wellbeing apart from health

(3 6) /doctor/access

*** Definition: gaining entry to the program by seeing doctor; time to first dose
(3 7) /doctor/consultation
*** Definition: availability of doctor for consultation

(3 8) /doctor/transfer
*** Definition: issues about obtaining transfers between the chemist and clinic or transfers to other programs

(3 9) /doctor/status concerns
*** Definition: statements expressing a sense of moral evaluation of clients by doctor

(4) /pharmacist

(4 1) /pharmacist/dose level
*** Definition: alterations to the prescribed dose by the pharmacist

(4 2) /pharmacist/pharmacy takeaways
*** Definition: issues related to getting takeaway doses from the pharmacy

(4 3) /pharmacist/interest
*** Definition: pharmacists showing expressions of interest in clients

(4 4) /pharmacist/trust
*** Definition: expressions of trust in clients by pharmacist

(4 5) /pharmacist/cost
*** Definition: statements about cost of dispensing fees or affordability of program

(4 6) /pharmacist/access
*** Definition: obtaining right to dose at pharmacy; time to first dose at pharmacy

(4 7) /pharmacist/dosing time
*** Definition: issues regarding dosing time at clinic, including time taken to dose, hours of dosing

(4 8) /pharmacist/status concerns
*** Definition: statements expressing a sense of moral evaluation of clients by pharmacist
(5) /institution

(5 1) /institution/addicts

*** Definition: description of addict stereotypes; self-perceptions in relation to stereotype

(5 2) /institution/work

*** Definition: statements related to effect of program on work commitments or capacity to obtain or retain work

(5 3) /institution/being open

*** Definition: openness to others about being a client on the program; effects of the decision to be open on relationships (but not work)

(5 4) /institution/compare interstate

*** Definition: evaluative comparisons of SAHS and an interstate ORT program

(5 5) /institution/compare other NSW

*** Definition: evaluative comparisons of SAHS and a large city based ORT program

(5 6) /institution/clinic takeaways

*** Definition: comments about policy on takeaway doses from the clinic
## Appendix D – Conceptually Ordered Matrix of Client Resource Exchanges

<table>
<thead>
<tr>
<th>EXCHANGE SOURCE</th>
<th>RESOURCE CATEGORY</th>
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<tbody>
<tr>
<td>Love</td>
<td>Status</td>
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<tr>
<td>Case worker</td>
<td>Follow-ups</td>
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<td></td>
<td>Helpfulness</td>
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<td></td>
<td>Persistence</td>
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<tr>
<td></td>
<td>Compare</td>
</tr>
<tr>
<td></td>
<td>other NSW</td>
</tr>
<tr>
<td>Prescriber</td>
<td>Learning</td>
</tr>
<tr>
<td></td>
<td>Interest</td>
</tr>
<tr>
<td></td>
<td>Status</td>
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<tr>
<td></td>
<td>concerns</td>
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<td></td>
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<tr>
<td>Pharmacist</td>
<td>Dose</td>
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<tr>
<td></td>
<td>level</td>
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<tr>
<td></td>
<td>Interest</td>
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<td></td>
<td>Trust</td>
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<td>concerns</td>
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<tr>
<td>Institution</td>
<td>ORT &amp; SAHS</td>
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<tr>
<td></td>
<td>reasons *</td>
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</tbody>
</table>

*Note:  * = clients appeared to have three basic reasons for entering ORT and the SAHS program. These were to gain support (love), to stop their drug cravings with methadone (goods) and to reduce the cost of their drug use (money). Two codes – client time in ORT and client time in the SAHS - were used only for describing the participants; they contained no thematic material and are not included in the matrix.

+ = applies to clinic dispensing staff, not pharmacist
### A: DEMOGRAPHIC INFORMATION

1. What is your sex?
   - Male: 1
   - Female: 2

2. What is your age? ____________________________

3. In what country were you born? ____________________________

4. If you were not born in Australia, in what year did you first arrive?
   - 19___

5. What is your main language?
   - English: 1
   - Other: 2
   
   *(Specify ____________________________)*

6. Are you aboriginal?
   - No: 1
   - Yes, Aboriginal: 2
   - Yes, Torres Strait Islander: 3
   - Yes, Aboriginal AND Torres Strait Islander: 4
   - Unknown: 0
7. How many years of school have you completed?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Years 1-6</td>
<td>2</td>
</tr>
<tr>
<td>Years 7-10</td>
<td>3</td>
</tr>
<tr>
<td>Years 11-12</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
</tr>
</tbody>
</table>

8. Have you completed any courses after school?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Yes: trade/technical</td>
<td>2</td>
</tr>
<tr>
<td>Yes: university/college</td>
<td>3</td>
</tr>
</tbody>
</table>

9. What is your relationship status at the moment?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>1</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>De facto</td>
<td>3</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
</tr>
<tr>
<td>Separated</td>
<td>5</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
</tr>
</tbody>
</table>

10 (a). How many children do you have?

10 (b). How many children are currently in your care?

10 (c). Do you require child care to attend appointments?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
</tbody>
</table>

11. Are you employed at the moment? (Circle only one)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not employed</td>
<td>1</td>
</tr>
<tr>
<td>Part-time/casually</td>
<td>2</td>
</tr>
<tr>
<td>Full-time</td>
<td>3</td>
</tr>
<tr>
<td>Student</td>
<td>4</td>
</tr>
<tr>
<td>Home duties</td>
<td>5</td>
</tr>
<tr>
<td>Pensioner</td>
<td>6</td>
</tr>
<tr>
<td>Sickness benefits</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
</tbody>
</table>

(Specify ____________________________ )
12. What is the postcode where you live?

('NFA' = If homeless)

13. How long have you been in your current treatment at the Killard Centre?

Years ______ Months ______

14. How many times have you been enrolled in treatment at the Killard Centre? (if more than once, why was there a break)

15. How long have you been in methadone treatment in total?

Years ______ Months ______

16. How many times have you been in methadone treatment in total? (where greater than one month break)

17. Which of the following treatments other than methadone maintenance have you been in?

None 0
Detoxification 1
Drug free counselling 2
Therapeutic counselling 3
Narcotics Anonymous 4
Other 5

(Specify ______________________)

18. What is your current dose of methadone? ______ mg

(5mg = 1ml)

19. Is that dose:

Stable 0
Increasing 1
Reducing voluntarily 2
Reducing involuntarily 3
20. Is this dose:

- Too high: 0
- Okay: 1
- Too low: 2

21. In the last month, how many sessions/appointments have you had with:

- Prescriber: ________
- Case worker: ________

22. How much longer do you expect to stay in treatment at this program?

- Transferring: 0
- Detoxing now: 1
- <3 months: 2
- 3-6 months: 3
- 7-12 months: 4
- 1-2 years: 5
- >2 years: 6
- Don't know: 7

23. Using the following scale, which of the following aspects of treatment do you think you need and how important for you is it that they be met?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all Important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not very Important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately Important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely Important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- To feel support and acceptance: ________
- To not feel judged or evaluated: ________
- To receive information: ________
- To get cost effective treatment: ________
- To get the right dose of methadone: ________
- To get ready access to services eg. consultations, counselling: ________

B: DRUG USE

1. How old were you when you first abused any drug? ________ years
2. What drug was it?

- Heroin: 1
- Methadone: 2
- Other opiates: 3
- Amphetamines: 4
- Cocaine: 5
- LSD: 6
- Ecstasy: 7
- Benzodiazepines: 8
- Alcohol: 9
- Cannabis: 10
- Inhalants: 11
- Steroids: 12
- Other: 12

(Specify ________________________)

3. Which substance is presently your main problem?

- No problem: 0
- Alcohol – any use: 1
- Alcohol – to intoxication: 2
- Heroin: 3
- Methadone (illicit): 4
- Other opiates: 5
- Tranquillisers: 6
- Speed: 7
- Cocaine: 8
- Cannabis: 9
- Hallucinogens: 10
- Inhalants: 11

4. How serious would you rate your current drug problem?

- No problem: 0
- Mild: 1
- Moderate: 2
- Serious: 3
- Out of control: 4
5. In the last month, what drugs have you used?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>1</td>
</tr>
<tr>
<td>Methadone</td>
<td>2</td>
</tr>
<tr>
<td>Other opiates</td>
<td>3</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>4</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5</td>
</tr>
<tr>
<td>LSD</td>
<td>6</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>7</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>8</td>
</tr>
<tr>
<td>Alcohol</td>
<td>9</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10</td>
</tr>
<tr>
<td>Inhalants</td>
<td>11</td>
</tr>
<tr>
<td>Steroids</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
</tbody>
</table>

(Specify ________________________)

6. On the last day you used them, how much did you have?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
</tr>
<tr>
<td>Other opiates</td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>LSD</td>
<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

(Specify ________________________)
7. How regularly on that day?

Heroin   ___
Methadone ___
Other opiates ___
Amphetamines ___
Cocaine ___
LSD ___
Ecstasy ___
Benzodiazepines ___
Alcohol ___
Cannabis ___
Inhalants ___
Steroids ___
Other ___

(Specify ________________________ )

8. How many times in the last month have you had them?

Heroin   ___
Methadone ___
Other opiates ___
Amphetamines ___
Cocaine ___
LSD ___
Ecstasy ___
Benzodiazepines ___
Alcohol ___
Cannabis ___
Inhalants ___
Steroids ___
Other ___

(Specify ________________________ )
C: HEALTH

Physical Health
1. Dependence related: Have you had any of the following general health problems:

   Fatigue/energy loss 1
   Weight loss/underweight 1
   Poor appetite 1
   Trouble sleeping 1
   Fever 1
   Night sweats 1
   Swollen glands 1
   Jaundice 1
   Bleeding easily 1
   Bruising easily 1
   Teeth problems 1
   Eye/vision troubles 1
   Ear/hearing troubles 1
   Cuts needing stitches 1

   TOTAL ______

2. Please circle which of the following problems you have had as a result of injecting in the last month, if any:

   Overdose 1
   Blood spills 1
   Abscesses/infections 1
   Dirty hit (made me sick) 1
   Hepatitis B 1
   Hepatitis C 1
   Prominent scarring/bruising 1
   Difficulty injecting 1
   Thrombosis 1

   TOTAL ______

3. Non-dependence related: Do you suffer from any general medical conditions?

   If so, specify _________

Psychological Health – MMCI
Social Functioning

1. In the last month, how often have you had conflict with your relatives, partner, children or friends?

- Very often: 4
- Often: 3
- Sometimes: 2
- Rarely: 1
- Never: 0
- Not applicable: 0

2. About how many close friends would you estimate that you have? (Include partners)

- None: 4
- One: 3
- Two: 2
- Three: 1
- Four or more: 0

3. When you are having problems, are you satisfied with the support you get from your friends?

- Very satisfied: 0
- Satisfied: 1
- Reasonably satisfied: 2
- Not satisfied: 3
- Very unsatisfied: 4
- Not applicable: 0

4. About how often have you seen your friends in the last month?

- Very often: 0
- Often: 1
- Sometimes: 2
- Rarely: 3
- Never: 4
- Not applicable: 4
5. How many of the people you hang around with now have you known for more than a month?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4</td>
</tr>
<tr>
<td>Less than half</td>
<td>3</td>
</tr>
<tr>
<td>About half</td>
<td>2</td>
</tr>
<tr>
<td>More than half</td>
<td>1</td>
</tr>
<tr>
<td>All of them</td>
<td>0</td>
</tr>
<tr>
<td>Not applicable</td>
<td>0</td>
</tr>
</tbody>
</table>

6. How much of the last month have you been living with anyone else who uses heroin?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>4</td>
</tr>
<tr>
<td>Most of the time</td>
<td>3</td>
</tr>
<tr>
<td>Half of the time</td>
<td>2</td>
</tr>
<tr>
<td>Some of the time</td>
<td>1</td>
</tr>
<tr>
<td>None of the time</td>
<td>0</td>
</tr>
</tbody>
</table>

7. How many of the people you hang around with are now users? (Include partners)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Less than half</td>
<td>1</td>
</tr>
<tr>
<td>About half</td>
<td>2</td>
</tr>
<tr>
<td>More than half</td>
<td>3</td>
</tr>
<tr>
<td>All of them</td>
<td>4</td>
</tr>
</tbody>
</table>

8. How many different places have you lived in over the last month?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>0</td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
</tr>
<tr>
<td>Three</td>
<td>2</td>
</tr>
<tr>
<td>Four</td>
<td>3</td>
</tr>
<tr>
<td>Five or more</td>
<td>4</td>
</tr>
</tbody>
</table>

9. How much of the last month have you been unemployed?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>4</td>
</tr>
<tr>
<td>Most of the time</td>
<td>3</td>
</tr>
<tr>
<td>Half of the time</td>
<td>2</td>
</tr>
<tr>
<td>Some of the time</td>
<td>1</td>
</tr>
<tr>
<td>None of the time</td>
<td>0</td>
</tr>
</tbody>
</table>
10. How many different full-time jobs have you had in the last month?

One 0
Two 1
Three 2
Four or more 3
None 4

11. Have you had any personal crises in the last month that have affected your attitude to life? (eg. death of a loved one, imprisonment, homelessness etc.)

No 0
Yes 1

(Specify ____________________)

D: CLIENT SATISFACTION QUESTIONNAIRE (18-B)

1. When you first came to our program, were you seen as promptly as you felt necessary?

Yes, very promptly 4
Yes, promptly 3
No, there was some delay 2
No, it seemed to take forever 1

2. In general, how satisfied are you with the comfort and attractiveness of our facility?

Quite dissatisfied 1
Indifferent or mildly dissatisfied 2
Mostly satisfied 3
Very satisfied 4

3. Did the characteristics of our building detract from the services you have received?

Yes, they detracted very much 1
Yes, they detracted somewhat 2
No, they did not detract much 3
No, they did not detract at all 4
4. How satisfied are you with the amount of help you have received?

Quite dissatisfied 1
Indifferent 2
Mostly satisfied 3
Very satisfied 4

5. Considering your particular needs, how appropriate are the services you have received?

Highly appropriate 4
Generally appropriate 3
Generally inappropriate 2
Highly inappropriate 1

6. Have the services you received helped you to deal more effectively with your problems?

Yes, they helped a great deal 4
Yes, they helped somewhat 3
No, they really didn't help 2
No, they seemed to make things worse 1

7. When you talked to the person with whom you have worked most closely, how closely did he or she listen to you?

Not at all closely 1
Not too closely 2
Fairly closely 3
Very closely 4

8. Did you get the kind of service you wanted?

No, definitely not 1
No, not really 2
Yes, generally 3
Yes, definitely 4
9. Are there other services you need but have not received?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, there definitely are</td>
<td>1</td>
</tr>
<tr>
<td>Yes, I think there are</td>
<td>2</td>
</tr>
<tr>
<td>No, I don’t think there are</td>
<td>3</td>
</tr>
<tr>
<td>No, there definitely are not</td>
<td>4</td>
</tr>
</tbody>
</table>

10. How clearly did the person with whom you worked most closely understand your problem and how you felt about it?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very clearly</td>
<td>4</td>
</tr>
<tr>
<td>Clearly</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat unclearly</td>
<td>2</td>
</tr>
<tr>
<td>Very unclearly</td>
<td>1</td>
</tr>
</tbody>
</table>

11. How competent and knowledgeable was the person with whom you have worked closely?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor abilities at best</td>
<td>1</td>
</tr>
<tr>
<td>Only over average ability</td>
<td>2</td>
</tr>
<tr>
<td>Competent and knowledgeable</td>
<td>3</td>
</tr>
<tr>
<td>Highly competent and knowledgeable</td>
<td>4</td>
</tr>
</tbody>
</table>

12. How would you rate the quality of service you have received?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>4</td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
</tr>
<tr>
<td>Fair</td>
<td>2</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
</tr>
</tbody>
</table>

13. In an overall general sense, how satisfied are you with the service you have received?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>4</td>
</tr>
<tr>
<td>Mostly satisfied</td>
<td>3</td>
</tr>
<tr>
<td>Indifferent or mildly dissatisfied</td>
<td>2</td>
</tr>
<tr>
<td>Quite dissatisfied</td>
<td>1</td>
</tr>
</tbody>
</table>
14. If a friend were in need of similar help, would you recommend the program to him or her?

- No, definitely not 1
- No, I don't think so 2
- Yes, I think so 3
- Yes, definitely 4

15. Have the people in the program generally understood the kind of help you wanted?

- No, they misunderstood almost completely 1
- No, they seemed to misunderstand 2
- Yes, they seemed to generally understand 3
- Yes, they understood almost perfectly 4

16. To what extent has the program met your needs?

- Almost all of my needs have been met 4
- Most of my needs have been met 3
- Only a few of my needs have been met 2
- None of my needs have been met 1

17. Have your rights as an individual been respected?

- No, almost never respected 1
- No, sometimes not respected 2
- Yes, generally respected 3
- Yes, almost always respected 4

18. If you were to seek help again, would you come back to the program?

- No, definitely not 1
- No, I don’t think so 2
- Yes, I think so 3
- Yes, definitely 4
Appendix F – Coding System for Transcripts of Client Interviews

A. Overview

This system was developed in conjunction with an unstructured interview designed to identify elements of treatment considered significant by individual clients of the SAHS. The interview begins by inviting respondents to identify events or aspects of treatment about which they have had strong feelings and beliefs, either positive or negative, which may have impacted on their perception of, or engagement with, themselves and/or the program. Those who show difficulty identifying any notable elements of treatment are assisted by being invited in general terms to evaluate their engagement with one of the main service providers involved in their treatment (i.e., their prescriber, dispenser and, where available, case worker). Respondents who remain unable to provide any material for discussion are then asked for their evaluation of a number of specific elements of treatment applicable to their particular circumstances, including, but not limited to, for example, access to the program; treatment costs; access to takeaways and transfers; dose setting; and access to ancillary services such as counselling. All interviews are transcribed verbatim for the purpose of analysis.

The general unit of analysis in each transcript of interview is a single event or aspect of treatment identified by individuals as impacting on them while clients of the SAHS. Each event or element of treatment is analysed according to the respondent’s evaluation of it, which may be directly reported or inferred from a series of related indirect comments. The analysis occurs in two stages. First, the event as a whole is rated according to its perceived valence for the respondent and whether it occurs within the context of his or her relationship with either one of the major service providers (i.e. the dispenser, case worker or prescriber) or the program more generally. Second, the event itself is ascribed a brief summary title and rated according to its importance; the resource exchange it represents; whether the respondent’s expectations were met; and the attitudinal or behavioural outcomes that ensue from it for the respondent and/or the program. Each of these elements is considered individually in the following sections.

Results are recorded using the coding summary sheet (see Appendix G). The time required to analyse each transcript ranges from approximately 40 minutes to two hours and reflects not only the amount of material identified by the respondent but also its coherence and vagueness. (While notable features of respondent engagement such as emotionality, incoherence, vagueness, passivity and abstraction et cetera do not form part of the analysis, they should be recorded on the coding sheet for audit purposes.) It is recommended that the entire interview be read before coding commences in order to familiarise the coder with the span of topics nominated by the respondent and to enable the coder to gain a sense of the comprehensiveness with which they are presented over the course of the interview.
B. Identifying Events and Issues

An analysable event or aspect of treatment is the smallest discrete cluster of ideas focused on a common theme that contains an evaluative statement by the respondent. Information related to a single issue may be presented linearly within a single segment of text or it may be scattered in various places throughout the transcript. Multiple references to a topic usually occur as part of the respondent’s elaboration of ideas over time or as an indication of the importance of the topic to that person. In such instances, the issue is coded only once. However, if the same topic is identified as having occurred with several different service providers (e.g., two separate examples of the same problem with transfers, one of which occurred with the case worker and another which occurred with the prescriber), the issue is coded separately for each provider involved. (Upon elaboration, apparently similar issues often reveal subtly different concerns for the respondent because of the difference in role of the service provider involved.) Similarly, if in speaking about a feature of the program generally (i.e., one not based on a relationship with a service provider) a respondent recounts several instances of the issue, it is coded only once unless there is evidence that the respondent is attributing a slightly different meaning to each. (Differences in meaning suggest that different types of resources are being exchanged. See ‘Identifying the Resource Exchanged’ below.)

After identifying an appropriate event or element of treatment, two criteria need to be met in order to regard it suitable for analysis:

1. The event or aspect of treatment must have occurred during the respondent’s enrolment on the SAHS program. For ease of analysis, this is most likely to be during the individual’s current enrolment in treatment. However, given that some clients may drop out of treatment and re-enrol or transfer from one area to another within the SAHS, it is possible that the events they identify will not be recent or relate to their current dosing site. These types of events are appropriate for analysis. Occasionally respondents may refer to events which reflect outdated practices or policies of the SAHS. These are also analysable as they provide important information on the acceptability of changes within the program. More frequently, however, clients will identify events of significance that relate to their time on programs outside the SAHS, such as in metropolitan Sydney or the ACT. While these do not meet the criteria for an analysable event because they do not relate to their enrolment on the SAHS, the material they contain can provide noteworthy information on prior experiences that informs their current expectations for treatment (see ‘Identifying and Assessing Expectations’ below).

2. The event must have been experienced directly by the respondent or, in the case of an opinion about an aspect of treatment, be the respondent’s own personal belief. Frequently clients will provide hearsay evidence of the experiences of friends or acquaintances on the program. Often this will serve as an example to reinforce their personal beliefs about an issue, which are later more or less directly elaborated on. As such, they are analysable. Occasionally, however, some seemingly evaluative remarks, even upon
probing, appear to have no particular personal meaning or relevance and, as such, contain insufficient information upon which to ascertain a particular issue of concern. For example, respondents frequently label methadone treatment as 'liquid handcuffs' in sympathy with the common understanding of this term among the majority of clients on the program. Sometimes this opinion is voiced merely as a statement reflecting the authenticity of the individual's membership in a treatment group, not because the term is associated with a particular experience on the program or has personal significance. (e.g. 'We're the ones with the liquid handcuffs') By themselves, these remarks cannot be coded.

Where for practical purposes an interview has had to be conducted with a couple each of whom is enrolled in the program, both partners may express the same or similar views about a particular event or issue. As partners tend toward concordance, not divergence, in their publicly stated views, there is the risk of attributing to both of them events or issues which may ordinarily be identified as personally important by only one of them. In order to avoid artificially inflating the record of significant treatment events or issues in this way and given that the coding reflects the experiences of individuals in treatment, an event or issue is typically associated only with the party who initiates discussion on it. As such, it is coded once regardless of the degree of agreement by the partner. The following interchange is such an example:

B. And with payment too he'll jump down your throat.
A. If you're behind with your payments.
B. Oh, yeah. And like I explained to him, he was really good this time, because I said to him, 'I'm out of action. I can't work.' And he wrote a note in the book saying don't hassle me and he's given me until the end of the month to square things up, which was very good of him. So he can be really kind and cool.
A. Yeah.
B. But then I think he must have problems on his plate too.
A. Yeah. He has his days.
B. So when he's in a bad humour, he'll take it out on whoever is around him, you know. And I don't think it's only us. A lot of the staff there...
A. Oh, yeah.
B. ...get driven hard. That's just his nature so we understand it.
A. Yes.

In this case, while person A, a female, obviously agrees with and helps to clarify the views expressed by person B, her partner, the issue about late payments with the chemist is coded as relating only to person B.

Occasionally an event may have been experienced jointly by both respondents or different examples of the same issue may be highlighted by each of them. Using the above example, if person A subsequently reported a similar experience of problems with late payments at the chemist and were able to reflect on her individual reactions to this, the issue would also be coded for her according to the particular meaning she ascribed it.
When registering an event on the coding summary sheet, it is assigned a brief title of no more than half a dozen words that most succinctly captures the essence of the issue involved but provides maximum distinction from other related events. Using the above example, an appropriate title would be ‘Late payment at the chemist’.

C. Rating Valence

Respondents will frequently evaluate events and issues as being either positive or negative in a direct statement to this effect, typically when discussing the impact of the experience on them. Occasionally, particularly upon subsequent reflection or when considering issues at length, respondents will reveal significant ambivalence about a topic, reporting a balance of positive and negative features of the issue. In these circumstances where no clear summary statement or other evidence of the underlying value or worth of the event or issue is presented, it may be inferred from an examination of the respondent’s assessment of the outcome of the issue. (While it is possible, for example, that an event may have a positive outcome for a client regardless of the objectionable circumstances that produced it, unless the individual indicates in some way that the end did not justify the means, it cannot be assumed that the event was regarded as anything other than positive.)

The event is reported under either the ‘positive’ or ‘negative’ section of the coding summary short against either the provider it relates to or the program itself.

D. Identifying the Source of Events and Issues

Unless a direct attribution is made, events or aspects of treatment are coded as relating to one of the three main service providers (i.e. the prescriber, dispenser or case worker) when the respondent regards the outcome of the issue as dependent in some way on the bailiwick or control of that party. As a general guide, topics coded as involving the exchange of particularistic resources, such as love, status and services, almost always only occur in the context of a relationship with a service provider. Where the issue is not seen to be affected by the actions of an individual service provider, it is most likely to be coded as relating to the program generally. Some examples include:

1. Issues related to program policies and protocols, such as, for example, the maximum number of allowable weekly takeaways for clients, dosing hours at sites, delays in gaining access to the program or rules around rates of dose change. (If, however, the issue is about a service provider’s discretionary application of a rule, the incident would be coded as relating to that provider. For example, if a respondent complained that the doctor would prescribe only two weekly takeaways when he or she was entitled to four, the issue would be coded as relating to the prescriber because it reflects a personal decision on the part of the service provider based on a personal assessment of the client that is somehow in dispute. Similarly, if a client feels aggrieved because dosing staff appear to allow some to dose outside the prescribed clinic hours, the issue is associated with the perceived inconsistency in behaviour of the dispenser.)
2. Client reflections on the effects of methadone or buprenorphine as drugs in and of themselves (e.g. their ability to stop cravings or their side effects) are almost always coded as features of the general program. An exception would be where the client believed the effect of the drug changed because the pharmacist was watering down the doses, for example.

3. Issues involving the physical infrastructure of the treatment which cannot be readily changed at the clinic level, such as the location and convenience of dosing sites and their layout. (Note: issues reflecting operational decisions by service providers such as pharmacists made in their capacity as sole proprietors of a business are usually coded as relating to the dispenser because they are implemented at their discretion and not in accordance with broader program policy. Examples include the provision of separate dosing areas, the size of the dispensing fee charged, rules of dress or behaviour in the pharmacy and dosing hours.)

Clinic based clients are invariably dosed on occasion by their case worker in conjunction with other dosing staff. Where incidents or issues arise at the dosing site and the case worker is involved, the issue is coded as having occurred with the dispenser because it was in that capacity that the case worker was operating at the time. (Moreover, because doses are dispensed in the presence of two staff, the issue is often identified as relating to both people operating in unison, one of whom is employed solely as a dispenser.)

E. Rating Importance

An event or aspect of treatment is rated as being important to a client if it is initially raised spontaneously by him or her and is not simply a response to a question by the interviewer about a specific aspect of the program that the interviewer may have deemed applicable to that person, such as, for example, dosing hours or methadone costs. (As stated in the Overview, such questions result only because the respondent has shown difficulty identifying any issue to discuss and seems unable to reflect on any aspect of his or her engagement with the key treatment providers.) This distinction is highlighted by the following example:

Q. Now you dose at the pharmacy. How do you find that?
A. It’s good.
Q. What do you find is useful about that?
A. Um, well, it’s in town. It’s close to home. That’s all, really.
Q. Okay. So it’s pretty convenient. Do you get takeaways at all?
A. Yeah.
Q. And how many of those do you get a week?
A. Oh, three or four a week, yeah.
Q. And how does that system work for you?
A. Oh, it’s good. I like it.

This is an excerpt from an interview with an extremely shy young male who apologised at the start of the interview for being ‘not much of a talker’. As such, he initiated almost no discussion which would indicate the important aspects of the
program for him. These could only be delineated by his responses to the most broadly based questions about the program or the people in it. For example, the client says in response to the first question that he finds the pharmacy environment good because it is close to home. This positive evaluation of the location of the pharmacy is rated as being important to him because the question was non-directive enough to have elicited discussion on many different features of the pharmacy, such as the cost of the methadone there, the nature of the service provided by the pharmacist or the way the drug is dispensed et cetera. In other words, the question did not pre-empt a response about the value of the location per se.

Further on, however, the client answers a specific question about how he finds the takeaways, to which he provides a positive evaluation. This second response would be coded as being not important because it is unclear, regardless of the valence he ascribes it, how much the availability of takeaways matters to him. (He could have, for instance, raised the issue of takeaways when asked how he finds the pharmacy but did not.) If, however, when asked a question about a specific feature of the program the respondent made a statement to the effect that the issue was important to him and he would have raised it had he remembered (e.g. ‘Oh, actually, that reminds me’ or ‘Well, now you mention it. that’s something I did want to raise’) the issue would then be rated as important.

If once an issue has been initially identified by the respondent subsequent probes are required by the interviewer to elicit further details about the event, these are not considered to negatively impact on the perceived importance of the event. That is the case in the following example where the event is coded as important because the respondent initially identifies a problem associated with the rigidity of clinic rules:

Q. Okay. So what you’re saying it sounds like there are rules about things and they’re stuck to.
A. Yeah, yeah.
Q. Can you give me an example. You said, you know, you turned up 10 minutes late and it sounds like you haven’t been able to get your dose.
A. Yes.
Q. Can you just go through with me what happened there.
A. Um, well, the first thing, you know, I arrived late and the first thing that was said to me was, ‘Well, you know the hours’, and I was quite upset about that because, um, um, you know, I was doing something that was important.

On the coding summary sheet, responses are simply rated as either ‘important’ or ‘not important’. (Rating events as ‘not important’ is not intended to imply that they are of no value to the client; it is used as a counterpoint shorthand for ‘important’ to indicate that their worth has not been otherwise established.)

F. Identifying the Resource Exchanged

Based on the ideas of Foa and Foa (1974), all client engagements with treatment can be symbolised as involving the exchange of one of six resource types: love, status, information, services, goods and money. The exchanges can be identified in the following forms:
1. Exchanges symbolising *love* are found in respondent descriptions indicating the presence or absence of some kind of attachment with a service provider denoting the presence or absence of goodwill, respect, trust, agape or friendship. Evidence of an interest in client wellbeing and caring behaviours that extend outside the expected role of the service provider are typical examples of love exchanges reported by respondents.

2. Exchanges involving *status* are those where the respondent has somehow been reminded of his or her position as a methadone or buprenorphine client and that he or she is different from people in the general community because of it. Engagements where the respondent feels that a service provider has exercised the power of his or her role for its own sake also fall into this category. In short, status exchanges are based on *intergroup* or role distinctions whereas love exchanges are based on the interpersonal relationship features between the respondent and a service provider. For example, reports of exchanges of status frequently include generalised references to the respondent being a member of a group that is discriminated against (e.g. 'Oh, well, it happened because I’m a junkie and that’s how they treat junkies') or where a service provider seemed to act for no other reason than he or she could (e.g. ‘It’s his show and if we don’t like it, that’s just too bad.’) By contrast, a similarly valenced exchange involving the category of love would reflect a lack of care or personal dislike on the part of the provider towards the respondent as an individual (e.g. ‘She just doesn’t give a damn about me.’)

3. *Information* exchanges are reflected in remarks by the respondent about the perceived competence or knowledge of a service provider (e.g. ‘If I have a question, the doctor will always have an answer or be able to get one for me’) or his or her understanding based on personal experience (e.g. ‘She gets what it’s like because she’s been there and done it herself’). Comments about the provision of information about treatment not related to the role of a particular provider would be coded at the program level (e.g. ‘I’ve found the brochures in the waiting room of the clinic really helpful and have tried to read them all so I can find out what’s around’).

4. Interactions involving exchanges of *services* are as the name suggests: engagements where respondents reflect on the provision of some *non-material* program activities, such as takeaways, dosing times, program access, counselling, urinalysis, time taken to dose and service provider availability and accessibility et cetera. An unusual though not infrequent topic of importance to respondents is the ability of the program’s format (e.g. through its dosing hours or physical layout or location) to enable them to minimise their contact with other clients, which they see as important in their efforts to avoid relapse into drug use. While engagements between clients per se are not analysable because such interactions are not limited to their time on the program, the effectiveness of the program in influencing their encounter at the point of treatment is. Primarily this occurs through the structures and procedures of the services.
provided and, as such, is coded at the level of the program. Occasionally, however, it occurs through the efforts of the dispensing staff, who may decide to contact the police, for instance, when one client physically assaults another. The respondent’s reflections on the dispenser’s protection of his or her safety in this instance would then be coded against the dispenser.

5. Exchanges of *goods* relate not only to issues regarding the treatment drug itself, such as its side effects and effectiveness, but also the setting of dose levels. As discussed in the section on relational sources of exchange (see D2), respondent reflections on the drug itself are frequently coded at the level of the program generally. However, events and issues concerning setting an appropriate dose may or may not implicate the prescriber. For example, reports of getting help with setting dose levels from the doctor (e.g. ‘We figure it out together, which is really helpful’) would be coded against the prescriber while reflections on the difficulty of finding the right dose which suggest a solitary struggle over time (e.g. ‘It’s taken me a long time to find a dose that will hold me without putting me on the nod’) would be coded against the program generally.

6. *Money* exchanges are represented in respondent discussions of payment issues, such as arrangements for the late or non-payment of goods, and the cost of treatment. As considered in section D3, unless the respondent raises an issue about charging for treatment per se (e.g. ‘It’s just not right that you should have to pay for it; it never used to be case’), which would be coded as a feature of the program generally, all other issues around payment can generally be sourced to the policies of individual chemists and so would be coded against the dispenser. For example, respondents frequently discuss the impact of differences in the pricing policies of chemists in various locations which appear to be based on the proprietor’s discretion.

While it is quite likely that a single treatment encounter or program feature may encompass the exchange of several resources, it is the resource that symbolically captures the essence of the exchange that is of sole interest for analysis. Importantly, this primary resource is inferred not by the event or issue per se but by the *meaning ascribed to it by the respondent*. For example, respondents may complain about not being served in the order of general customers as they enter the chemist and describe how they are consistently served last. On first reading, this could be construed as an exchange with the dispenser involving the resource of services. Upon elaboration, however, the respondents relay that this is proof that methadone clients are second-class citizens and that ‘junkies’ are not seen by ‘straight people’ as deserving of the same rights. In this instance, then, the event would be more appropriately coded as an exchange of status because of the report of perceived discriminatory behaviour on the part of the pharmacist. Importantly, if the respondents did not elaborate on the problem of being served in order but reported it simply as the problem it was (i.e. did not ascribe any motive to the chemist other than his or her desire to implement a policy to serve methadone clients last), it would be coded as an exchange involving services.
Client Satisfaction with Opioid Replacement Treatment

G. Identifying and Assessing Expectations

The aim of identifying expectations is to ultimately assess whether or not they were met in the event of interest. Generally, respondent expectations of issues or events are not directly reported and must be inferred from the overall tenor of their comments. (In fact, when directly asked, most respondents have difficulty articulating what they expected in the circumstance. Upon examination, however, their comments often reveal that they have firmly-held beliefs about what should or should not have happened.) As such, this is one of the most difficult aspects of the coding process. The following types of comments are often signposts of implicit unmet expectations:

1. ‘Should’ statements. These are most likely to arise when the respondent is reporting a negative experience and is describing how the issue could have been better dealt with.

2. Comparisons with past experience. As considered in the section on analysing events (see B1), respondent evaluations of their prior experiences with treatment often provide an indication of what they have learnt to expect from methadone programs. Engaging in comparison suggests that there is some discrepancy between what has happened in the past and current experiences, which implies an unmet expectation.

3. Emotive statements. The activation of either positive or negative emotion and statements to this effect suggests that an outcome was unexpected in some way for the respondent. In text, the unexpected result is clearly conveyed as either a pleasant surprise or a bitter disappointment. The expression of this attitude must be qualitatively different from an evaluation of the incident as merely positive or negative. This distinction is highlighted in the following examples:

A. And I couldn’t believe—and their attitude was, ‘Tough titties.’ you know. ‘You know the rules.’ You know, and I just—I can’t believe it’s like that. And you know, in this day and age, it shouldn’t be like that. It shouldn’t be so Stalinist.

Apart from the ‘should’ statements, which also indicate an unmet expectation, this male respondent is also angry and clearly expresses disbelief at his experience. By contrast, the following example reveals the absence of an emotional response to an incident:

A. I don’t know—people just say methadone is a really bad drug and, I don’t know, it’s even more addictive than heroin and stuff. I don’t know. I just find it different like that.
Q. So you haven’t found it as addictive as they’ve said it was?
A. Mm, yeah. But I’d rather be on methadone than on heroin.

While this male respondent has found methadone less addictive than he expected it to be, in this instance the unmet expectation is ascertained by his clear statement to that effect, not by the nature of his emotional engagement with the topic.
Expectations are assumed to have been met when, apart from direct comments as such, respondents provide no evidence that the event or issue differed in any respect from what they anticipated. Typically, this can be inferred when the respondent raises an issue but sees no need to elaborate on it in any depth, despite probing, and gives the impression that, while noteworthy, the topic is unproblematic (e.g. 'That's just the way these things are'). Accordingly, the issue appears to be raised in a fleeting way and only once in the interview. (Note: given that the interview asks respondents to reflect on significant events or aspects of their treatment, reports of circumstances where respondents' expectations were met are infrequent.)

On the coding summary sheet, expectations are coded as either 'met' or 'not met' and a brief description of the expectation is listed.

H. Identifying and Classifying Outcomes
Outcomes are identified as the end result of an incident or the consequences of an issue on the respondent. Where a respondent's expectations have not been met in an event, the outcome often effects either behavioural or attitudinal change and on either the self of the respondent and/or the other party—namely, the program generally or service providers within it. Where expectations are met, no change is expected to result from the event.

Outcomes are classified as producing either behavioural or attitudinal change (and not both) because behavioural change is considered a specific byproduct of attitudinal change. As such, classifying an outcome as having produced a change in behaviour presupposes a changed attitude. However, an outcome classified as having produced a change in attitude is merely that. Together, the four factors of 'behaviour', 'attitude', 'self' and 'other' produce the following combination of outcomes:

1. **A change in attitude to the self.** This is coded when the respondent reports a change in self-esteem, confidence or self-perception as a result of the event (e.g. 'I didn't know I had it in me to be able to deal with it') or a change in emotion (e.g. 'I felt really bad because of it').

2. **A change in attitude to the other.** This reflects a change in attitude or emotional regard towards either a service provider (e.g. 'He's really helpful') or the program generally (e.g. 'If I had my time over, I wouldn't enroll on this program again'). Importantly, expressions of intent to act which have not been manifested (e.g. 'Well, I won't be contacting her again for assistance') are recorded as changes in attitude, not behaviour.

3. **A change in attitude to self and other.** This code applies when the criteria for 1 and 2 above are met (e.g. 'He's so helpful that I now feel compelled to be completely honest with the guy').

4. **A change in behaviour to the self.** This indicates some action has been taken by the respondent on his or her self as a result of the event or issue. Typical
examples include abstaining from or returning to drug use, seeking or dropping out of treatment and lifestyle changes. While any of these behaviours may have an impact on the respondent's engagement with the program, the action is intended to primarily and directly affect the respondent's self.

5. *A change in behaviour to the other.* This is coded when the respondent takes action against either a service provider or, at the program level, the bureaucracy that administers the treatment. It may take the form of verbal or written complaints or compliments, a change in frequency of treatment engagement (e.g. 'I now go straight to her when I've got problems') or any outcome indicating active rather than passive engagement in treatment.

6. *A change in behaviour to the self and the other.* This is coded when the criteria for 4 and 5 above are met (e.g. 'I told him what for and then went out and got on."

7. *No change.* This is recorded when the respondent’s expectations for the event or issue were met.

Outcomes are coded on the summary sheet in accordance with one of the above seven categories along with a brief description of the outcome.
Appendix G – Coding Summary Sheet

<table>
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<tr>
<th>ID</th>
<th>DATE</th>
<th>GENDER</th>
<th>AGE</th>
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**Personal needs (Notable results from questionnaire data)**

<table>
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<tr>
<th>DEMOGRAPHIC DETAILS</th>
<th>DRUG USE/PHYSICAL HEALTH</th>
<th>SOCIAL FUNCTIONING</th>
<th>PSYCHOLOGICAL FUNCTIONING</th>
<th>SERVICE CONTACT</th>
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**Prescriber engagements**

**POSITIVE EVENTS**

<table>
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<tr>
<th>EVENT</th>
<th>IMPORTANT (YES/NO)</th>
<th>RESOURCE REPRESENTED</th>
<th>EXPECTATION MET (YES/NO)</th>
<th>OUTCOME</th>
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**NEGATIVE EVENTS**

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<th>EVENT</th>
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## Dispenser engagements

### POSITIVE EVENTS

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## Case worker engagements

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**Program engagements**

### POSITIVE EVENTS

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**Notable features of interview engagement**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Details</th>
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<tbody>
<tr>
<td>EMOTIONALITY</td>
<td>(e.g. teary, angry, nervous)</td>
</tr>
<tr>
<td>COHERENCE</td>
<td>(e.g. quality &amp; quantity of speech, relevance, clarity and order of thought)</td>
</tr>
<tr>
<td>ABSTRACTION</td>
<td>(e.g. links ideas)</td>
</tr>
<tr>
<td>PASSIVITY/VAGUENESS</td>
<td>(e.g. little initiative in conversation)</td>
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</table>
## Appendix H – Subset Codes for the Resource Categories

<table>
<thead>
<tr>
<th>Resource Type</th>
<th>Subset Code</th>
<th>Definition</th>
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<tbody>
<tr>
<td></td>
<td>Goodwill</td>
<td>Evaluations of provider interest in the client’s wellbeing or devotion to the client’s betterment, frequently manifested through behaviour or acts</td>
</tr>
<tr>
<td>Love</td>
<td>Respect</td>
<td>Evaluations of provider awareness of the client’s need for privacy and the maintenance of trust in the treatment relationship</td>
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<tr>
<td></td>
<td>Acceptance</td>
<td>Evaluations of provider neutrality towards the client; expressions of support of the client’s self-direction</td>
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<tr>
<td></td>
<td>Warmth</td>
<td>Evaluations of provider friendliness; provider recognition and appreciation of the person of the client; examples of positive emotional exchange between the provider and client</td>
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<tr>
<td></td>
<td>Genuineness</td>
<td>Evaluations of honest, authentic, non-defensive attitudes in the provider toward the client; provider capacity for self-disclosure, forthrightness and the expression of positive and negative feelings</td>
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<tr>
<td>Status</td>
<td>Stereotype</td>
<td>Evaluations of provider attitudes suggesting that the client belongs to a group that is marginalised or stigmatised by society</td>
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<td></td>
<td>Exposure</td>
<td>Evaluations of provider activities that highlight that the client has been stereotyped and which provide public information about the nature of the stereotype</td>
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<tr>
<td>Services</td>
<td>Dosing time</td>
<td>Evaluations related to the hours available to receive a dose or the time taken to dose</td>
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<tr>
<td>Physical facility</td>
<td>Evaluations of the physical features of the dosing site that impact on the nature of client interaction or levels of client safety and comfort</td>
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<tr>
<td>Program access</td>
<td>Evaluations of the waiting time to gain entry to the program or the requirements for admission to the program</td>
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<tr>
<td>Rules</td>
<td>Evaluations of policy or program rules regarding takeaway limits, dosing intoxicated clients, compulsory case consultation, urine testing, transfers or other services</td>
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<tr>
<td>Consultation</td>
<td>Evaluations associated with access to providers or the ease and flexibility with which they can organise services such as takeaways, transfers or counselling</td>
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<tr>
<td>Information</td>
<td>Information</td>
<td>Evaluations of provider knowledge of drug issues based on either expertise or experience; availability of information on drug issues in the program itself.</td>
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<tr>
<td>Drug</td>
<td>Evaluations of the side effects of the pharmacotherapy when the dose level is either stable or reducing; issues associated with attempts to withdraw from the pharmacotherapy drug and lead a drug-free life.</td>
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<tr>
<td>Drug level</td>
<td>Evaluations regarding the planning, setting and maintenance of an appropriate dose level; provider assistance with treatment planning and the determination of contraindications, including other medication</td>
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<tr>
<td>Money</td>
<td>Treatment cost</td>
<td>Evaluations of the cost of the treatment</td>
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<tr>
<td></td>
<td>Late payment</td>
<td>Evaluations of provider attitudes regarding the provision of credit arrangements to clients and their management</td>
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</tbody>
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